Rm#_____
EGD/Colonoscopy_____
Colonoscopy_____

PATIENT HISTORY FORM

Date of office consultation:_____ **Date form completed:** _____ **Patient age:** _____
Last name: _____ **First name:** _____ **Middle initial:** _____
Primary Care Doctor: _____
Please provide name(s) of other physicians(s) that you have visited within the last year: _____
_____

Reason(s) for your visit to a Gastroenterologist (please include duration of your symptoms if applicable):
_____
_____

Have you started any new medication (prescription, nonprescription, vitamins, probiotics, and supplements) within 3 months of the onset of your symptoms? _____Yes ____No
If yes, please list only those medications(including antibiotics) you started within 3 months of the onset of your symptoms: _____
_____
_____

For FEMALE patients, is there any correlations between your symptoms and your menstrual period (if applicable)?
____Yes ____No
If yes, please briefly describe:_____
_____

Have you been experiencing any of the following (please place a check mark next to those that apply to you):

____ Nausea
____ Vomiting
____ Burning in chest
____ Acid or bitter taste in the back of your throat
____ Voice hoarseness
____ Awakening in the middle of the night with coughing or shortness of breath
____ Sensation of food being stuck in your throat or chest after swallowing
____ Pain when you swallow
____ Feeling full shortly after starting a meal
____ Loss of appetite
____ Chest pain
____ Shortness of breath
____ Coughing
____ Abdominal bloating
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Thinning of the stool on a consistent basis
____ Rectal Bleeding
____ Pain in rectal area
____ Black stool
____ Unintentional weight loss
____ Fever and/ or chills
____ Stool incontinence (I.e. loss of control of bowel movements)
____ Other:
_____
_____
_____
_____
____ COVID- 19 Infection _____
_____

Please describe any other symptoms you have been experiencing that are not listed above: _____
_____
_____
_____

For office use only
Weight: _____ Height: _____ BMI: _____ Temp: _____ BP: _____ HR: _____ Other: _____
Medical Clearence: ____Yes ____No Diabetic____Yes ____No Type I or II Insulin dependent: ____Yes ____No

- **For FEMALE patients only:**
  Date of last menstrual period: _____
  Are you or could you be pregnant at this time? ____ Yes ____ No
  Date of your last gynecologic exam: _____
  Date of last mammogram: _____

Please check all that may apply to you:

- **Heart Conditions:**

____ Heart Attack(s)
If yes, date(s): _____
____ Heart murmur
If yes, date(s): _____

____ Aortic Stenosis
____ Heart arrhythmia
If yes, what type? _____

____ Mitral Valve prolapse
____ Taking blood thinners
If yes, name of med: _____

- **Heart Procedures:**

____ Stents
If yes, date: _____
____ Heart bypass surgery
If yes, date: _____

____ Angioplasty
If yes, date: _____
____ Pacemaker or ICD
If yes, date: _____

____ Heart ablation
If yes, date: _____
____ Heart valve surgery/procedure
If yes, date: _____

- **Heart Tests:**

____ Stress Test
If yes, date: _____

____ Echocardiogram
If yes, date: _____

____ Holter Monitor
If yes, date: _____

- **Past Medical History (please place a check mark next to those that apply to you):**

____ Blood clotting disorder
If yes, type: _____
____ Excessive bleeding during procedure or surgery. If yes, name of procedure and date when occurred _____
____ Angina
____ Congestive Heart Failure
____ Fainting
____ Rheumatic Fever
____ High Blood Pressure
____ Elevated Cholesterol
____ Pneumonia
____ Asthma
____ Emphysema
____ Sleep Apnea
____ Anemia
____ Blood Transfusion
If yes, year: _____
____ Thyroid Disease;
Underactive or Overactive
____ Diabetes: Type _____
Insulin Dependent ____Yes ____No
____ Stroke

____ Seizure Disorder
____ Head Injury
____ Migraine Headaches
____ Kidney Stones
____ Kidney Failure
____ HIV infection
____ Herpes
____ Mononucleosis
____ Tuberculosis
____ Psoriasis
____ Infection with organism resistant to antibiotics? If yes, please list: _____
____ Endometriosis
____ Ovarian Cyst
____ Lupus
____ Gout
____ Arthritis
____ Leukemia or Lymphoma
____ Schizophrenia
____ Fibromyalgia
____ Depression
____ Bipolar Disorder

____ Transplant of any organ?
Please specify: _____
____ Hip Replacement or any other prosthesis? Please specify: _____
_____
____ Spine problems
____ Cancer
If yes, type: _____
Diagnosis date: _____
Surgery? Type: _____
Treatment? Type: _____
(chemotherapy/radiation)
Date(s) of treatment: _____
____ MRSA
Diagnosis date: _____
Treated? ____Yes ____No
Location of infection? _____
_____

Have you ever been tested for the AIDS virus? ____ Yes ____ No. _____
Have you received antibiotic prophylaxis for procedures, including dental? ____ Yes ____ No
If yes, please describe: _____
_____
Please describe any other medical disorders not listed above: _____
_____

- **History of Gastrointestinal, Digestive and Liver Diseases** (place check next to those that apply to you)

____ Colon Cancer	____ Ulcers	____ Celiac Sprue
____ Colon Polyps	____ Helicobacter Pylori Infection	____ Gallstones
____ Colon Surgery	____ Stomach Surgery	____ Gallbladder Surgery
____ Ulcerative Colitis	____ Stomach Cancer	____ Hepatitis ___ A, ___B, or ___C
____ Crohn's Disease	____ Barrett's' Esophagus	____ Other Liver Disease
____ Diverticulosis	____ Acid Reflux (GERD)	____ Hemorrhoids
____ Diverticulitis	____ Hiatal Hernia	____ Achalasia
____ Pancreatitis	____ Removal of Appendix	

Please describe any other gastrointestinal, digestive, liver disease or surgery not listed above: _____
_____

- **History of Gastrointestinal and Liver Procedures/Radiologic Studies (please give dates of any of the following procedures/studies you have completed):**

Flexible Sigmoidoscopy: _____ Barium Enema: _____
Colonoscopy: _____ Liver Biopsy: _____
CAT Scan: _____ MRI: _____
Pelvic Ultrasound: _____ Other: _____
Upper Endoscopy: _____
Upper GI series (x-ray after swallowing barium):_____

- **Please list any prior hospitalizations:**

Reason for Hospitalization	Date
_____	_____
_____	_____
_____	_____

- **Please list any prior surgeries (not already listed):**

Please describe surgical procedure performed	Date
_____	_____
_____	_____
_____	_____

- **Please provide consent to having your medication list imported**: ____ Yes ____ No
- **Are you allergic to any medications?**

If yes, please list: _____
_____

- **Do you have any other allergies?** ____ Yes ____ No

If yes, please list: _____
_____

- **Do you take aspirin?** ____ Yes ____ No. Dose: _____ 81 mg or _____ 325 mg

How often do you take aspirin? (i.e. daily, 1 x week, etc.): _____

- **Do you take Advil, Aleve, Motrin or similar anti-inflammatory medication?** ____ Yes ____ No

If yes, name: _____ Dose: _____ How often? (i.e. daily, 1 x week, etc.): _____

- **Do you take antacids or acid blocking medication such as Mylanta, Zantac, Pepcid, Prilosec or Prevacid?**

____ Yes ____ No If yes, name of medication: _____ Dose: _____

How often? (i.e. daily, 1 x week, etc.): _____

- **Please provide the names and doses of the medications you are currently taking (including prescription, non-prescription, vitamins, probiotics and supplements):**

Name of Medication/Supplement	Dose (ex. 10mg, 20mg)	Frequency (ex. 1 per day, 2 per day)	Date Started (Estimate)

OTHER HISTORY

- **Do you smoke cigarettes**? ____ Yes ____ No

If yes, how many cigarettes per day? _____

- **Are you a former smoker?** ____ Yes ____ No

If yes, how many cigarettes per day? _____ For how many years? _____ When did you stop? _____

- **Do you drink alcoholic beverages?** ____ Yes ____ No

If yes, how many drinks per day/week/month? (measured as 1 ounce scotch = 1 beer = 1 glass of wine) _____

Occupation: _____ Marital Status: _____ Number of Children: _____

Family History

Gastrointestinal, digestive, or liver disease:

Please list the relatives who have been diagnosed with the following disorders and age at which he/she was diagnosed:

Colon Cancer: _____ Ulcers: _____

Colon Polyps: _____ Helicobacter Pylori Infection: _____

Ulcerative Colitis: _____ Liver Disease: _____

Crohn's Disease: _____ Gallbladder Disease: _____

Other gastrointestinal, digestive or liver disease not described above: _____

- **Your Family's General Medical History:**

	Age	Medical Problems	Deceased?	If yes, cause?
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother/Sister	_____	_____	_____	_____
(specify)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Children	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Other (Aunt/Uncle,				
Grandparents)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- **Dietary History**

Please describe the foods you typically have for the following meals:

	Food	Beverage
Breakfast	_____	_____
Lunch	_____	_____
Dinner	_____	_____
Snacks	_____	_____

- **Do you have a history of milk or other food intolerance?**

If yes, please describe: _____

_____

- **Do any of your symptoms occur either during or shortly after meals?**

If yes, please describe: _____

_____

- **Do you chew gum or consume other sugar containing products on a regular basis?**

If yes, please describe what you consume and how often: _____

_____