

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):

- | | | |
|--|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Stool incontinence (I.e. loss of control of bowel movements) |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Burning in chest | <input type="checkbox"/> Shortness of breath | _____ |
| <input type="checkbox"/> Acid or bitter taste in the back of your throat | <input type="checkbox"/> Coughing | _____ |
| <input type="checkbox"/> Voice hoarseness | <input type="checkbox"/> Abdominal bloating | _____ |
| <input type="checkbox"/> Awakening in the middle of the night with coughing or shortness of breath | <input type="checkbox"/> Abdominal pain | _____ |
| <input type="checkbox"/> Sensation of food being stuck in your throat or chest after swallowing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> COVID- 19 Vaccine |
| <input type="checkbox"/> Pain when you swallow | <input type="checkbox"/> Constipation | <input type="checkbox"/> Johnson & Johnson |
| <input type="checkbox"/> Feeling full shortly after starting a meal | <input type="checkbox"/> Thinning of the stool on a consistent basis | <input type="checkbox"/> Moderna Date: 2 nd dose _____ |
| | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Pfizer Date: 2 nd dose _____ |
| | <input type="checkbox"/> Pain in rectal area | <input type="checkbox"/> Booster Date: _____ |
| | <input type="checkbox"/> Black stool | <input type="checkbox"/> Non- Vaccinated |
| | <input type="checkbox"/> Unintentional weight loss | |
| | <input type="checkbox"/> Fever and/ or chills | |

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 Clearance: _____ 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)

- | | | |
|---|--|--|
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Celiac Sprue |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Helicobacter Pylori Infection | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Stomach Surgery | <input type="checkbox"/> Gallbladder Surgery |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Stomach Cancer | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A, <input type="checkbox"/> B, or <input type="checkbox"/> C |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Barrett's' Esophagus | <input type="checkbox"/> Other Liver Disease |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Acid Reflux (GERD) | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Achalasia |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> 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:**

<u>Reason for Hospitalization</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____

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

<u>Please describe surgical procedure performed</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____

• **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):**

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

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:**

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

• **Dietary History**

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

	<u>Food</u>	<u>Beverage</u>
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: _____
