

GASTROENTEROLOGY ASSOCIATES

Comprehensive Health History

Patient Name _____ Age _____ Date _____

Referring Doctor _____ Family Doctor _____

What is the **main problem** you are here for today? _____

May we leave appointments, simple results and instructions on your home answering machine? Initial if ok _____

PLEASE BRING A LIST OF YOUR CURRENT MEDICATIONS OR BRING THE MEDICATIONS IN THEIR ORIGINAL CONTAINER.

Review of Systems

Please check the **symptoms you currently have or have recently had.**

Negative except as noted below and in HPI.

- | | | |
|---|---|---|
| <input type="checkbox"/> Heartburn or Indigestion | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Black tarry stools |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Weight Loss (_____lbs.) |
| <input type="checkbox"/> Chronic sore throat | <input type="checkbox"/> Diarrhea (loose stools) | <input type="checkbox"/> Fevers (highest temp _____) |
| <input type="checkbox"/> Chest Pains (not heart) | <input type="checkbox"/> Constipation (hard stools) | <input type="checkbox"/> Shaking Chills |
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Rectal Pain | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Pencil thin stools | |
| | | |
| <input type="checkbox"/> Soaking Night Sweats | <input type="checkbox"/> Heart pain (angina) | <input type="checkbox"/> Frequent nighttime urination |
| <input type="checkbox"/> Unusual Cold Intolerance | <input type="checkbox"/> Swollen feet/ankles | <input type="checkbox"/> Skin: Rash or Ulcers |
| <input type="checkbox"/> Unusual Heat Intolerance | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Unusual Dry Eyes | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Vaginal Bleeding |
| <input type="checkbox"/> Unusual Dry Mouth | <input type="checkbox"/> Sudden loss of vision | <input type="checkbox"/> Excessive menstrual bleeding |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Sudden arm/leg weakness | <input type="checkbox"/> Excessive menstrual pain |
| <input type="checkbox"/> Productive cough | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Burning upon urination | <input type="checkbox"/> Joint Pains |

Your Past Medical History (Have you personally ever had any of the following problems?)

GI

- | | | |
|---|---|--|
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Gastric Ulcer | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Duodenal Ulcer | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> H. pylori gastritis | <input type="checkbox"/> Cholelithiasis |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> GERD | <input type="checkbox"/> Acute Idiopathic Pancreatitis |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Esophageal Stricture | <input type="checkbox"/> Gallstone Pancreatitis |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Alcohol related Pancreatitis |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Chronic Pancreatitis |
| <input type="checkbox"/> Ischemic Colitis | <input type="checkbox"/> Hepatitis C | |
| <input type="checkbox"/> Infectious Colitis | <input type="checkbox"/> Hepatitis | |

Cardiac

- | | |
|---|--|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Dyslipidemia |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Valvular Heart Disease | <input type="checkbox"/> Dysrhythmia |
| <input type="checkbox"/> Endocarditis | |

Pulmonary

- | |
|---|
| <input type="checkbox"/> Asthma |
| <input type="checkbox"/> COPD |
| <input type="checkbox"/> Chronic Bronchitis |
| <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Histoplasmosis |

Your Past Medical History (continued)

Endocrine

- Diabetes Mellitus
- Hypothyroidism
- Hyperthyroidism
- Graves' Disease
- Thyroid Cancer

OB/GYN

- Polycystic Ovarian Syndrome
- Endometriosis
- Ovarian Cancer
- Uterine Cancer
- Breast Cancer
- Fibrocystic Breast Disease

Hematology

- Leukemia
- Lymphoma
- Anemia
- Sickle Cell Disease
- Myelodysplasia
- Blood Transfusion

Renal Diseases

- Chronic Kidney Disease
- Dialysis
- Renal Cancer
- Polycystic Kidney Disease
- Kidney Stones
- Interstitial Cystitis
- Benign Prostatic Hypertrophy
- Prostate Cancer

Ortho/Rheum

- Rheumatoid Arthritis
- Osteoarthritis
- Spinal Stenosis
- Vertebral Compression Fractures

- TIA
- Migraine Headaches
- Depression
- Bipolar Disorder
- Schizophrenia
- Anxiety
- Other Psychiatric Disease

Neurology/Psychiatry

- Parkinson's Disease
- Alzheimer's Disease
- Stroke

Have you personally ever had any of the following surgical procedures?

Surgical History

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Splenectomy | <input type="checkbox"/> Salpingo-oophrectomy |
| <input type="checkbox"/> Coronary Angioplasty | <input type="checkbox"/> Partial Colectomy | <input type="checkbox"/> Cesarean Section |
| <input type="checkbox"/> Coronary Stent | <input type="checkbox"/> Total Colectomy | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Lysis of Adhesions | <input type="checkbox"/> Knee Replacement |
| <input type="checkbox"/> Implantable Cardiac Defibrillator | <input type="checkbox"/> Bariatric Surgery | <input type="checkbox"/> Hip Replacement |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gastric Surgery for Ulcers | <input type="checkbox"/> Other joint replacement |
| | <input type="checkbox"/> Nissen Fundoplication | <input type="checkbox"/> Back Surgery |

Colorectal Cancer Screening – Date _____ Breast Cancer Screening – Date _____

Social History

Marital Status: Married Single Divorced Widowed **Occupation** _____

Children Living Deceased Age at Death _____ Cause of Death _____

Smoking Status: Current every day smoker Current some day smoker Former Smoker (Date quit _____)
 Never Smoker *If current or quit within 12 months:* Cigarettes Cigars Pipe Smokeless

Language: _____ **Race:** White African American American Indian/Alaskan Asian
 Hawaiian/Pacific Islander Other **Ethnicity:** Hispanic or Latino Not Hispanic or Latino

Alcohol: Y N Rarely Drinks: _____ Per Day _____ Per Week **Caffeine:** Y N Cups: _____ Per Day _____ Per Week

Drug Use: Y N Type _____ Frequency _____

Family History

Mother Alive Deceased Age now or at death _____ Cause of Death _____
Father Alive Deceased Age now or at death _____ Cause of Death _____
Brothers _____ Alive Deceased Age at Death _____ Cause of Death _____
Sisters _____ Alive Deceased Age at Death _____ Cause of Death _____

Please note if your Mother, Father, Brothers, Sisters, or Grandparents had any of the following:

<u>Disorder</u>	<u>Relative</u>	<u>Disorder</u>	<u>Relative</u>	<u>Disorder</u>	<u>Relative</u>
Esophageal Cancer	M F B S GM GF	Colon Cancer	M F B S GM GF	Uterine Cancer	M F B S GM GF
Gastric Cancer	M F B S GM GF	Colon Polyps	M F B S GM GF	Ovarian Cancer	M F B S GM GF
Liver Cancer	M F B S GM GF	Crohn's Disease	M F B S GM GF	Heart Attack	M F B S GM GF
Other Liver Disease	M F B S GM GF	Ulcerative Colitis	M F B S GM GF	Diabetes	M F B S GM GF
Pancreas Cancer	M F B S GM GF	Bleeding Ulcers	M F B S GM GF	Emphysema	M F B S GM GF
Pancreatitis	M F B S GM GF	Breast Cancer	M F B S GM GF		

Patient Name _____ DOB _____ DOS _____