

GASTROENTEROLOGY CONSULTANTS, PA

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Patient History Form

Name: _____ Date: _____

Referring Physician: _____ Date of Birth: _____

Reason for Visit: _____

Past Medical History: Please check if you or your family have ever had any of the following

Illness or Condition	You	Family	Illness or Condition	You	Family
Ulcerative Colitis or Crohn's Disease			TB		
Ulcer			High Blood Pressure		
Colon polyps or Colon Cancer			High Cholesterol		
Liver Disease			Diabetes		
Pancreatic Disease			Thyroid Disease		
Bleeding Disorder			Kidney Disease		
Have you ever had a Blood Transfusion			Seizures		
Lung Disease			Psychiatric Disorder		
Heart Disease			Depression		

Date of last colonoscopy _____
 Number of Pregnancies _____ Number of Live Births _____ Currently using Contraception: Yes No
 Hepatitis A Vaccine _____ Hepatitis B Vaccine _____

Please list all surgeries and recent hospitalizations:

Date	Reason for surgery or hospitalization

Family History:

Relative	Age	Living	Deceased	Disease or Cause of Death
Father				
Mother				
Siblings				

Social History:

Marital Status: Single Divorced Married Widow/Widower Other
 Do you smoke? Yes No If yes, how many packs per day? _____
 Did you smoke? Yes No If yes, when did you quit? _____
 Do you drink alcohol? Yes No If yes, indicate on average how much and circle day, week, or month:
 _____ Beer per: Day Week Month
 _____ Glasses of wine per: Day Week Month
 _____ Mixed drinks per: Day Week Month
 Did you previously drink heavily? Yes No For how long did you drink heavily? _____
 Do you or have you ever-used street drugs? Yes No Do you have Tattoos? Yes No

Physician signature _____ Date _____

DO YOU HAVE ANY OTHER PROBLEMS YOU WANT TO DISCUSS?

Yes No

Please list all of your medications, including over the counter medications (If you need additional space, please bring a list to your appointment). Include Medication Name, Dosage and Number of times per Day:

Please list all allergies including medications, food, and environmental:

Medical History: Please check any of the conditions that represent a SIGNIFICANT problem for you:

General	(√)	Gastrointestinal	(√)	Musculoskeletal	(√)
Fever or chills		Abdominal pain		Broken Bones	
Night sweats		Nausea and vomiting		Joint replacement surgery	
Recent weight changes		Heartburn or indigestion		Gout	
Eyes	(√)	Gallbladder problems		Arthritis	
Glasses or contacts		Trouble swallowing		Bone or joint pain	
Glaucoma		Loss of appetite		Endocrine	(√)
Other eye problems		Diarrhea		Heat or cold intolerance	
Ears, Nose Mouth	(√)	Constipation		Hot flashes	
Nose bleeds		Rectal pain		Excessive thirst	
Sinus problems		Hemorrhoids		Flushing	
Earache		Blood in stool		Changes in body hair	
Dentures		Tarry stools		Skin	(√)
Hearing loss		Genitourinary	(√)	Rash, dryness or itching	
Respiratory	(√)	Painful urination		Jaundice	
Cough		Kidney stones		Easy bruising	
Wheezing		Frequency at night		Psoriasis or Eczema	
Shortness of breath		Urgency		Pigment changes	
Asthma		Slow or small stream		Neurological	(√)
Cardiovascular	(√)	Blood in urine		Numbness	
Chest pain		Leaking of urine		Headaches	
Heart palpitations		Poor bladder emptying		Stroke	
Irregular heart beat		Menstrual problems		Dizziness	
Heart attack or failure		Recurrent bladder infections		Paralysis	
Heart murmur		Abnormal vaginal bleeding		Psychiatric	(√)
Heart valve problems				Depression	
Blood clots				Anxiety	
Feet or ankle swelling				Other	

Patient signature _____

Date _____

Physician signature _____

Date _____