Gastroenterology Associates
PERSONAL HISTORY FORM

Name:_____Date:_____

Date of birth:_____ Sex: ☐ M ☐ F Occupation:_____

Briefly describe why you are being referred or your current symptoms: _____
_____
_____
_____
_____

Have you ever had a colonoscopy and/or flexible sigmoidoscopy? If so, when and by whom? _____
_____

List current medications:

Name	Dosage	How often	Name	Dosage	How often
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		

Have you had any of the following? (Please check)

☐ High blood pressure ☐ Diabetes ☐ Stroke ☐ Heart disease
☐ Rheumatic heart disease ☐ Kidney disease/stones ☐ Thyroid disease ☐ Cancer
☐ Tuberculosis ☐ Blood transfusions ☐ Bleeding tendency ☐ Asthma/emphysema
☐ Heart murmur ☐ Stomach ulcers ☐ Colon polyps ☐ Esophagitis
☐ Gall bladder disease ☐ Ulcerative colitis ☐ Crohn's disease ☐ Hepatitis/jaundice
☐ Diverticulitis

Drug Allergies: (Please list and describe)

Drug	**Reaction**	**Drug**	**Reaction**
1. _____	_____	4._____	_____
2. _____	_____	5._____	_____
3. _____	_____	6. _____	_____

Please list all prior surgeries and dates:

1. _____ 4._____
2. _____ 5._____
3. _____ 6. _____

List other hospitalizations:

1. _____ 4._____
2. _____ 5._____
3. _____ 6. _____

Social Habits:

Do you smoke? ☐ Now ☐ Previously _____packs/day for _____years

Do you drink alcohol? ☐ Now ☐ Previously How much per day/week?_____

Have you ever used recreational or intravenous drugs? ☐ Yes ☐ No

(over)

Patient Name: _____

Family History: Do you have a family history (parents and/or siblings) of: (Please check) If so, whom?_____

☐ Colon cancer _____ ☐ Colon polyps _____ ☐ Ulcerative colitis _____ ☐Heart disease_____

☐ Peptic ulcers _____ ☐ Gall bladder disease _____ ☐ Pancreatic cancer _____

☐ Kidney disease _____ ☐ Thyroid disease _____ ☐ High blood pressure _____

☐ Breast cancer _____ ☐ Uterine cancer _____ ☐ Crohn's disease _____

	Age	Alive (Y/N)	Health Problems / Cause of Death
Mother			
Father			
Siblings (Brother or Sister)			
Children			List Chronic Health Problems

DO YOU PRESENTLY HAVE (Please check)

Constitutional: ☐ Recent weight change ☐ Fatigue ☐ Fever Weight _____

Eyes: ☐ Double vision ☐ Glaucoma ☐ Cataracts ☐ Vision Loss

Ears, nose, mouth, throat: ☐ Ringing in ears ☐ Dizziness ☐ Hearing loss ☐ Nosebleeds ☐ Sinus trouble
☐ Bleeding gums ☐ Hoarseness

Cardiovascular: ☐ Heart murmur ☐ Chest pains ☐ Palpitations ☐ Shortness of breath
☐ Leg pains with walking ☐ Phlebitis

Respiratory: ☐ Cough ☐ Cough up blood ☐ Pain with breathing

Gastrointestinal: ☐ Trouble swallowing ☐ Nausea ☐ Vomiting ☐ Blood in stools ☐ Diarrhea
☐ Constipation ☐ Black stools ☐ Abdominal pain

Genitourinary: ☐ Frequent urination ☐ Painful urination ☐ Blood in urine ☐ Incontinence

Musculoskeletal: ☐ Muscle or joint pain ☐ Arthritis ☐ Gout

Skin: ☐Rashes ☐ Sores ☐ Itching

Psychiatric: ☐ Depression ☐ Anxiety ☐ History of psychiatric problems

Endocrine: ☐ Thyroid trouble ☐ Heat or cold intolerance ☐ Excess thirst or hunger

Hematologic: ☐ Anemia ☐ Swollen glands

Men: ☐Penile discharge ☐ Testicular pain or masses

Women: ☐ Irregular menstrual periods Date of last menstrual period_____
Date of last pelvic and breast exam_____Date of last mammogram_____

Are you currently being treated for any condition not mentioned above? ☐ Yes ☐ No
If Yes, please list_____
_____
_____
_____