

Gastrointestinal Healthcare PC

Medical and Family History Form

Please fill in the circles for the appropriate health information

NAME: _____ TODAY'S DATE: _____

CHART NO. _____ DATE OF BIRTH: _____

REASON FOR VISIT _____

REFERRING PHYSICIAN _____

Allergies

- | | | | | | | |
|----------------------------------|----------------------------------|---------------------------------|-----------------------------------|-------------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine | <input type="checkbox"/> Morphine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Versed |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Demerol | <input type="checkbox"/> Latex | <input type="checkbox"/> Novocain | <input type="checkbox"/> Propofol | <input type="checkbox"/> Tape | <input type="checkbox"/> Other _____ |

Past Medical Illnesses

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Cancer | <input type="checkbox"/> History of Suicide Attempts | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cirrhosis of Liver | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Frequent Urinary Tract Infection | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Reflux | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lupus | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines | <input type="checkbox"/> TB Skin Test Positive |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Duodenal Ulcer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Fatty Liver | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Back Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Other _____ |

Previous Surgeries

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Breast | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Kidney | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> C-Section | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Obesity Surgery | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> EGD/Upper Endoscopy | <input type="checkbox"/> Cardiac Surgery | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Prostate | |
| <input type="checkbox"/> ERCP | <input type="checkbox"/> Right Colon Resection | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Stomach | |
| <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Left Colon Resection | <input type="checkbox"/> Hysterectomy Partial | <input type="checkbox"/> Thyroid | |
| <input type="checkbox"/> Sigmoidoscopy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hysterectomy Total | <input type="checkbox"/> Tonsils | |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Heart Bypass Surgery | <input type="checkbox"/> Joint Surgery/Replacement | <input type="checkbox"/> Transplant Surgery | <input type="checkbox"/> Other _____ |

Social History Marital Status:

- Single Separated Married
- Divorced Widowed

Number of Children:

- 1 2 3 4 5 6+ None

Social History Exercise:

- I do not exercise I walk I jog I bike
- I swim I golf I do aerobics I lift weights

Social History Alcohol:

- Never More than 2 days/week
- Rarely Less than 2 days/week
- Daily I quit using alcohol

Social History

Tobacco:

- I use tobacco products
- Cigarettes
 - 1 Pack per day
 - 1 ½ pack per day
 - 2 packs per day
 - Greater than 2 Packs per day

I quit using tobacco products

I have never used tobacco products

Cigars

Smokeless tobacco

Social History Occupation:

Patient Occupation _____

REVIEW OF SYSTEMS (Current Symptoms)

Gastrointestinal:

<input type="radio"/> None	<input type="radio"/>	<input type="radio"/> black stools	<input type="radio"/>	<input type="radio"/> difficulty swallowing	<input type="radio"/>	<input type="radio"/> pain with bowel movement	<input type="radio"/>	<input type="radio"/> weight loss more than 10 lbs
<input type="radio"/> abdominal pain upper	<input type="radio"/>	<input type="radio"/> bloating	<input type="radio"/>	<input type="radio"/> flatulence/gas	<input type="radio"/>	<input type="radio"/> rectal bleeding	<input type="radio"/>	<input type="radio"/> weight gain less than 10 lbs
<input type="radio"/> abdominal pain lower	<input type="radio"/>	<input type="radio"/> change in bowel habits	<input type="radio"/>	<input type="radio"/> heartburn	<input type="radio"/>	<input type="radio"/> rectal urgency	<input type="radio"/>	<input type="radio"/> weight loss more than 10 lbs
<input type="radio"/> abdominal pain swelling	<input type="radio"/>	<input type="radio"/> constipation	<input type="radio"/>	<input type="radio"/> hemorrhoids	<input type="radio"/>	<input type="radio"/> reflux	<input type="radio"/>	<input type="radio"/> vomiting
<input type="radio"/> anal/rectal pain	<input type="radio"/>	<input type="radio"/> dairy intolerance	<input type="radio"/>	<input type="radio"/> mucus in stool	<input type="radio"/>	<input type="radio"/> soiling stool/incontinence		
<input type="radio"/> belching	<input type="radio"/>	<input type="radio"/> diarrhea	<input type="radio"/>	<input type="radio"/> nausea	<input type="radio"/>	<input type="radio"/> weight loss less than 10 lbs	<input type="radio"/>	<input type="radio"/> Other _____

Urinary:

- None pain with urination
- blood in urine sexually transmitted disease
- change in urinary frequency urinary incontinence
- kidney stones
- nocturnal urination Other _____

Cardiovascular:

- None chest pain with exertion/angina palpitations shortness of breath with exertion
- ankle swelling heart murmur as an adult shortness of breath when lying flat Other _____

Neurological:

- None numbness in extremities
- dizziness seizures
- fainting spells stroke/weakness
- frequent headaches tremors
- memory disturbance Other _____

Endocrine:

- None heat intolerance
- cold intolerance tremors
- excessive thirst
- hair change/loss Other _____

