Gastroenterology Consultants Patient History Form

Date: _____

Name: _____ Date of Birth _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who Referred you to Gastroenterology Consultants? _____

Chief Complaint (Why are you here?) _____

I usually have _____ bowel movements per ☐ day ☐ week ☐ month

I am here for:
- ☐ Screening for possible Colonoscopy (no symptoms, referred by primary doctor)
- ☐ Consult for possible Colonoscopy because of the following symptoms:
  - ☐ rectal bleeding
  - ☐ pain, where is the pain located? _____
  - ☐ diarrhea
  - ☐ constipation
  - ☐ other: _____
- ☐ Consult for possible EGD (scope of esophagus, stomach, and small bowel)
  What symptoms are you having?
  - ☐ acid reflux
  - ☐ heartburn
  - ☐ difficulty swallowing
  - ☐ pain, where is the pain located? _____
- ☐ Consult for liver disease/Hepatitis C

Illnesses (Check all that apply):

☐ NONE	☐ Asthma	☐ Heart Disease	☐ Irreg. Heartbeat
☐ Chest pain	☐ High Blood Pressure	☐ Stroke	☐ Arthritis
☐ Cancer	☐ High Cholesterol	☐ Thyroid disorder	☐ Depression/Anxiety

☐ Other:_____

Surgeries:	**Date:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other injuries or hospitalizations:

_____

_____

Female patients:

First day of last period: _____

How many times have you been pregnant? _____ How many deliveries? _____

How many vaginal births? _____ How many C-sections? _____

Name: _____ Date: _____

CURRENT MEDICATIONS:

Name & Dose: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you take any blood thinning medications, such as Coumadin or Plavix? If yes, which one and for what reason?

_____

Which doctor prescribes this medicine for you? _____

Medical Allergies:

☐ NONE ☐ Penicillan ☐ Sulfa ☐ Codeine ☐ Demerol ☐ Morphine
☐ Iodine ☐ Fentanyl ☐ Valium ☐ Versed ☐ IV Contrast

Other allergies or reactions: _____

FAMILY HISTORY:

Any family members (brothers, sisters, parents, grandparents) with the following?

Disease	Relationship	Age at diagnosis
Colon Cancer	_____	_____
	_____	_____
Colon/rectal polyps	_____	_____
	_____	_____
Peptic Ulcer disease	_____	_____
Galibladder disease	_____	_____
Liver disease	_____	_____
Crohn's disease	_____	_____
Ulcerative colitis	_____	_____
Irritable bowel syndrome	_____	_____

Is there any other cancer history in your family? (Please list relationship and type of cancer)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Name: _____ Date: _____

Please indicate the health status of your parents:

Mother: _____ Father: _____

Number of brothers _____ sisters _____ Please indicate any health problems below.

Number of children _____ Please indicate any health problems below.

Have you or any family members had any trouble with anesthesia? ☐ YES ☐ NO

Have you or any family members had any bleeding disorders? ☐ YES ☐ NO

SOCIAL HISTORY:

What is your current occupation? _____

Do you smoke? ☐ YES ☐ NO How much? _____

If you quit, how much did you smoke? _____ How many years did you smoke? _____

Do you drink alcohol? ☐ YES ☐ NO ☐ Rarely ☐ Occasionally ☐ Weekends ☐ Daily

How many caffeinated beverages do you consume daily? _____

REVIEW OF SYSTEMS: **(Circle YES or NO)**

Constitutional:

Weight Loss	YES	NO
Weight Gain	YES	NO
Fever	YES	NO
Fatigue	YES	NO

Eyes/Ears/Nose/Mouth/Throat:

Vision Loss	YES	NO
Double Vision	YES	NO
Dry Eyes	YES	NO
Dry Mouth	YES	NO
Hearing Loss	YES	NO
Difficulty Swallowing	YES	NO
Sore Throat	YES	NO
Ringing in ears	YES	NO

Cardiovascular:

Chest pain/pressure/tightness	YES	NO
Heart Attack	YES	NO
Irregular Heartbeat	YES	NO
Ankle Swelling	YES	NO
Angina	YES	NO
Palpitations	YES	NO
Heart Murmur	YES	NO

Respiratory:

Shortness of Breath	YES	NO
Cough	YES	NO
Phlegm	YES	NO
Asthma	YES	NO
Emphysema/COPD	YES	NO

Name: _____ Date: _____

Genitourinary:				
	Painful Urination	YES	NO	
	Blood in Urine	YES	NO	
	Bladder Infections	YES	NO	
	Kidney Stones	YES	NO	
Musculoskeletal:				
	Muscle Pain	YES	NO	
	Muscle Weakness	YES	NO	
	Joint pain/Arthritis	YES	NO	
Integumentary: (skin/breast)				
	Rashes	YES	NO	
	Dry Skin	YES	NO	
	Breast Mass	YES	NO	
	Breast Pain	YES	NO	
	Nipple Discharge	YES	NO	
Neurological:				
	Headaches	YES	NO	
	Seizures	YES	NO	
	Memory Loss	YES	NO	
	Weakness	YES	NO	
	Stroke	YES	NO	
	Nerve Injury	YES	NO	
	Coordination Problems	YES	NO	
Psychiatric:				
	Depression	YES	NO	
	Anxiety	YES	NO	
	Panic Disorders	YES	NO	
	Personality Disorder	YES	NO	If yes, what? _____
Endocrine:				
	Thyroid disease	YES	NO	
	Diabetes	YES	NO	
Hematologic/Lymphatic:				
	Anemia	YES	NO	
	Easy Bruising	YES	NO	
	Bleeding Tendencies	YES	NO	
	Platelet Disorders	YES	NO	
	Enlarged Lymph Glands	YES	NO	

ADDITIONAL COMMENTS OR MEDICAL HISTORY:

_____

_____

_____

_____

_____ _____

Provider's Signature Date