

PATIENT MEDICAL HISTORY

Patient Name: _____ Date: _____

Referring or family Physician: _____ Birthdate: _____

Preferred Pharmacy: _____

Briefly describe primary gastrointestinal problem(s) for which you are seeking medical attention:

1. _____
2. _____
3. _____

Describe any other associated symptoms you have had with the GI problem:

What tests have already been performed related to these problems?

(Copies of test results would be very helpful if available)

<u>Test Name</u>	<u>Date</u>	<u>Facility test performed</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Do you experience any of the following? (please circle yes or no)

- | | | |
|-------------------------|-----------------------------------|-------------------------------------|
| Yes/No nausea | Yes/No food sticking in chest | Yes/No chest pain |
| Yes/No vomiting | Yes/No heartburn (chest burning) | Yes/No intolerance to certain foods |
| Yes/No bloating | Yes/No indigestion (stomach area) | Yes/No diarrhea/constipation |
| Yes/No abdominal pain | Yes/No yellow jaundice | Yes/No increased appetite |
| Yes/No weight loss | Yes/No change in bowel habits | Yes/No rectal bleeding |
| Yes/No loss of appetite | Yes/No lack of control for stools | |

Previous surgeries and/or hospitalizations:

<u>Reason</u>	<u>Date</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Other active and previous medical problems:

<u>Reason</u>	<u>Date</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Current Medications and dosage (include over-the-counter medications):

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Allergies to medications (describe reaction):

1. _____
2. _____
3. _____

Patient Name: _____

Family History

Relationship	Male/Female	Living/Deceased	Age	Disease and/or cause of death
Mother	Female			
Father	Male			
Brothers and Sisters				
Sons and Daughters				

Is there any history in the extended family of: (please circle yes or no)

- | | | | |
|--------|------------|--------|-------------------------------|
| Yes/No | cancer | Yes/No | bowel problems/colitis |
| Yes/No | ulcers | Yes/No | long-standing abdominal pains |
| Yes/No | gallstones | Yes/No | liver problems |

Social History:

_____ single _____ married _____ divorced _____ widowed

Number of children: _____

Smoking history (amount and duration): _____

Alcohol history (amount and duration): _____

Type of employment _____

Additional comments _____

Review of Systems

- | | | | | | |
|--------|---------------------|--------|-----------------------|--------|------------------------|
| Yes/No | fatigue | Yes/No | feet swelling | Yes/No | lightheadedness |
| Yes/No | fever | Yes/No | poor circulation in | | |
| Yes/No | sweat/chills | | feet/hands | Yes/No | loss of interest or |
| | | Yes/No | rapid, pounding heart | | pleasure |
| Yes/No | rash | Yes/No | cough | Yes/No | can't decide or |
| Yes/No | itching | Yes/No | phlegm/blood | | concentrate |
| Yes/No | easy bruising | | production | Yes/No | oversleeping |
| | | | | Yes/No | difficulty sleeping |
| Yes/No | change in vision | Yes/No | urine burning | | |
| Yes/No | pain in eyes | Yes/No | frequent urination | Yes/No | agitation/restlessness |
| Yes/No | eye drainage | Yes/No | blood urine | Yes/No | depression |
| | | | | Yes/No | suicidal thoughts |
| Yes/No | change in voice | Yes/No | muscle aching | Yes/No | panic attacks |
| Yes/No | sore throat | Yes/No | joint pain/swelling | Yes/No | anxiety |
| Yes/No | ear aching, ringing | Yes/No | bone, spine pain | Yes/No | muscle tension |
| Yes/No | sinus drainage | Yes/No | backache | | |
| Yes/No | nose bleeds | Yes/No | leg cramps | Yes/No | enlarged glands |
| Yes/No | wheezing | Yes/No | headache | | |
| Yes/No | chest pain | Yes/No | numbness | | |
| Yes/No | shortness of breath | Yes/No | imbalance | | |