

**St. George Endoscopy Center**

**PATIENT MEDICAL HISTORY**

**Patient name:**

**Date:**

**Referring or Family Physician:**

**Date of Birth:**

**Briefly describe primary gastrointestinal problems) for which you are seeking medical attention:**

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

**What tests have already been performed related to these problems?**

Test Name	Date	Facility test performed
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**Do you experience any of the following? (please circle yes or no)**

Yes/No	NAUSEA	Yes/No	FOOD STICKING IN CHEST
Yes/No	VOMITING	Yes/No	HEARTBURN
Yes/No	BLOATING	Yes/No	INDIGESTION
Yes/No	ABDOMINAL PAIN	Yes/No	YELLOW JAUNDICE
Yes/No	WEIGHT LOSS	Yes/No	INCREASED APPETITE
Yes/No	CHANGE IN BOWEL HABITS	Yes/No	CHEST PAIN
Yes/No	LACK OF CONTROL FOR STOOLS	Yes/No	LOSS OF APPETITE
Yes/No	RECTAL BLEEDING		
Yes/No	INTOLERANCE TO CERTAIN FOODS		
Yes/No	DIARRHEA/CONSTIPATION		

**Family History**

Relationship Male/ Female Living / Deceased (Age) Disease and/or cause of death

Mother Female

Father Male

Brothers & Sisters

Sons & 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 PAIN

Yes/No GALLSTONES Yes/No LIVER PROBLEMS

**Social History:**

\_\_\_Single \_\_\_Married \_\_\_Divorced \_\_\_Widowed \_\_\_Number of Children