FAMILY HEALTH, PC
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Gasteroenterologists

# Patient History Form

MR #: _____

| Last Name | First Name | DOB |
|---|---|---|
| Marital Status: Single Divorced Married Widow/Widower | Occupation | Kind of Work |
| Primary Care Physician | Other doctors involved with your care: | |

## MEDICAL HISTORY

**Have you or the patient ever had or been diagnosed with any of the following? If yes, please check any that apply and explain in the Space provided. Is your family physician aware of any symptoms/illnesses that you have checked below?** ❑ Yes ❑ No

| SYSTEM | NO | YES | SYSTEM | NO | YES | SYSTEM | NO | YES | SYSTEM | NO | YES |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Gastrointestinal** | | | **Cardiac** | | | **Neurologic** | | | **Ear, Nose, Throat** | | |
| Diarrhea | | | High Blood Pressure | | | Seizures | | | Loose Teeth | | |
| Constipation | | | Low Blood Pressure | | | Weakness | | | Nosebleeds | | |
| Rectal Bleeding | | | Irregular Heartbeat | | | Migraines | | | Deafness | | |
| Change in BM's | | | Chest Pain | | | Previous Stroke | | | **Psychosocial** | | |
| Weight Loss | | | **Respiratory** | | | **Musculoskeletal** | | | Alcoholism | | |
| Heartburn | | | Asthma | | | Muscle Disease | | | Substance Abuse | | |
| Trouble swallowing | | | Pneumonia | | | Arthritis | | | Depression | | |
| Nausea | | | Bronchitis | | | Neck Pain | | | Anxiety Disorders | | |
| Vomiting | | | Chronic Cough | | | Back Pain | | | **Breast, Lumps** | | |
| Abdominal Pain | | | Hoarseness | | | Blood Disorders | | | **Cancer** | | |
| Polyps: Colon / Gastric (circle one) | | | Shortness of Breath | | | **Skin** | | | **Any symptoms/ Diseases not Listed above?** | | |
| Irritable Bowel | | | **Genitourinary** | | | Rash | | | | | |
| **Hepatic** | | | Blood in Urine | | | Bruises | | | | | |
| Liver Disease | | | Burning on Urination | | | **Ophthalmic** | | | **Please list below:** | | |
| Yellow Skin | | | **Endocrine/Metabolic** | | | Cataracts | | | | | |
| Hepatitis | | | Diabetes | | | Glaucoma | | | | | |
| Pancreatitis | | | Thyroid Disorders | | | Blindness | | | | | |

## HISTORY

**Please explain any YES answers in detailed description in the box provided.**

Have you ever had any surgery or been Hospitalized? ❑ No ❑ Yes

Have you had any problems with anesthesia? No ___ Yes ___ if yes, please list below:

| Surgeries | Dates | Hospitalizations other than surgery | Dates |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are you currently or have you ever used any Tobacco or Alcohol Products? ❑ No ❑ Yes

Alcohol: How many drinks ❑ Per day _____ ❑ Per week _____ ❑ Per month _____

Tobacco: How Many packs per day _____ For how many years? _____

Are you or have you ever used recreational/illicit drugs? ❑ No ❑ Yes

If yes, what kind?
For how long?

Are you currently taking any medications or drugs (including over –the-counter, prescription, birth control pills)? ❑ No ❑ Yes

| Medication | Dose | Times | Medication | Dose | Times |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Do you have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)? ❑ No ❑ Yes

## FAMILY HISTORY

**Please indicate if your family members have had any of the following conditions:**

| Condition | Relation to patient | Condition | Relation to patient | Condition | Relation to patient |
|---|---|---|---|---|---|
| Colon/Rectal Cancer ❑ No ❑ Yes | | Colon Polyps ❑ No ❑ Yes | | Heart Disease ❑ No ❑ Yes | |
| Celiac Disease ❑ No ❑ Yes | | Ulcerative Colitis ❑ No ❑ Yes | | Crohn's Disease ❑ No ❑ Yes | |
| Breast Cancer ❑ No ❑ Yes | | Ovarian Cancer ❑ No ❑ Yes | | Uterine Cancer ❑ No ❑ Yes | |
| Stomach Cancer ❑ No ❑ Yes | | Pancreatic Cancer ❑ No ❑ Yes | | Bleeding Problems ❑ No ❑ Yes | |

**Person Completing This Form/Relationship to Patient** _____ **Reviewed by Provider** _____ **Date** _____