GASTROENTEROLOGY HISTORY

Date _____

Name _____ Birth Date: _____

Marital Status (S M D W) Number of children _____ Who lives with you? _____

Occupation _____ Employer _____

FAMILY HISTORY

Father's age _____ Deceased ☐ Medical conditions _____
Mother's age _____ Deceased ☐ Medical conditions _____

Number of brothers living _____ Number deceased _____ Medical diseases _____
Number of sisters living _____ Number deceased _____ Medical diseases _____

DO YOU HAVE BLOOD RELATIVES WITH? List relation, age at time of cancer (i.e., <u>aunt, 53 yr</u>)

Crohns or Ulcerative Colitis	☐ Yes	☐ No	Colon cancer _____	☐ Yes	☐ No
Early Heart disease	☐ Yes	☐ No	Ovarian, uterine or breast cancer _____	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No	Esophageal cancer _____	☐ Yes	☐ No
Peptic ulcer disease	☐ Yes	☐ No	Stomach cancer _____	☐ Yes	☐ No
Gallbladder disease	☐ Yes	☐ No	Other cancers _____	☐ Yes	☐ No
Lupus (SLE) or Sprue	☐ Yes	☐ No	Pancreas, Liver Disease, or Cirrhosis _____	☐ Yes	☐ No

HABITS / DIET

Cigarette or cigar use? ☐ Yes ☐ No Packs / day _____ Date stopped _____
Chewing tobacco / pipe? ☐ Yes ☐ No
Use alcoholic beverages? ☐ Yes ☐ No What type of beverage and how many drinks /day? _____
Alcohol abuse history? ☐ Yes ☐ No If yes, last date of any alcohol use is _____
Injectable or nasally inhaled recreational drug use history? ☐ Yes ☐ No

Special Diet / Diet restriction _____ Number of caffeinated beverages per day _____

MEDICATIONS & DOSAGES (include laxatives, herbs, vitamins, and over the counter medications).

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ALLERGIES: 1. _____ 2. _____ 3. _____

I HAVE AN ALLERGY TO: ☐ Iodine ☐ Anesthetics ☐ Latex ☐ Foods ☐ Chemicals

PAST HISTORY

SURGERIES

_____ year _____
_____ year _____
_____ year _____
_____ year _____

MEDICAL ILLNESSES or HOSPITALIZATIONS

_____ year _____
_____ year _____
_____ year _____
_____ year _____

EVALUATION

RECENT BLOODWORK? ☐ Yes ☐ No
RECENT XRAYS? ☐ Yes ☐ No
RECENT HOSPITALIZATION? ☐ Yes ☐ No

ENDOSCOPIC STUDIES

PRIOR COLONOSCOPY? ☐ Yes ☐ No
PRIOR EGD (ENDOSCOPY)? ☐ Yes ☐ No

Please complete the back side

Name _____ Birth Date _____ Date _____

REVIEW OF CURRENT SYMPTOMS

CONSTITUTIONAL	Yes	No
Fever or chills		
Night sweats		
Fatigue		

APPETITE / WEIGHT	Yes	No
Loss of appetite		
Loss of weight		
Increase in weight		

GASTROINTESTINAL	Yes	No
Nausea		
Vomiting		
Heartburn		
Painful swallowing		
Food sticking in throat or choking		
Abdominal pain		
Diarrhea		
Constipation		
Blood in the stool		
Black stools		
Loss of control of bowel movements		

PULMONARY SYMPTOMS	Yes	No
Shortness of breath		
Cough		
Wheezing		

HEART SYMPTOMS	Yes	No
Chest pain		
Irregular heart beat or palpitations		
Heart Murmur		
Swelling/Edema of the feet or ankles		

NERVOUS SYSTEM	Yes	No
Dizziness		
Fainting		
Numbness/tingling of legs or hands?		

FEELINGS / EMOTIONS	Yes	No
Do you have trouble sleeping?		
Do you feel tense, nervous or anxious?		
Do you feel depressed, blue or sad?		

HEAD, EYES, NOSE, THROAT	Yes	No
Headaches		
Eye Disease		
Sinus Problems		
Mouth disease (dry/sores)		

GENITO-URINARY	Yes	No
Pain or burning with urination		
Leaking urine		
Blood in the urine		
Kidney stones		

MUSCULOSKELETAL	Yes	No
Back pain or muscles aching		
Pain, swelling or stiffness in joints		

SKIN	Yes	No
Skin rash or condition		
Itching		
Flushing		

HEMATOLOGIC / ENDOCRINE	Yes	No
Enlarged lymph nodes		
Easy bruising or bleeding		
Hot / Cold Intolerance		

EXPOSURES IN THE PAST YEAR?	Yes	No
Well water		
Foreign travel		
Camping, fishing, hunting, ticks		
Chemical exposures		

PAST MEDICAL HISTORY	Yes	No
Gastric / duodenal ulcers		
Pancreas disease		
Liver disease		
Diabetes		
Thyroid disease		
Hypertension		
Stroke or seizure (date of recent)		
Heart disease or heart attack		
Valvular heart disease		
Pacemaker or defibrillator		
Lung disease / asthma		
Kidney disease / dialysis		
Cancer		
Anemia / blood transfusion		
Blood clots (DVT, PE, etc.)		
Arthritis		
Any sexually transmitted disease		
Tuberculosis or positive PPD		
Glaucoma (high pressure in the eyes)		
Psychiatric disorder?		