Gastroenterology Specialists

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Medical History Questionnaire

Name _____ Appointment Date _____

Date of Birth _____ Age _____ Sex: Male _____ Female _____

☐ Referred by PCP ☐ Referred by _____ Family Physician _____

A. Reason for Visit: **Date it began**:

_____ _____

_____ _____

What concerns you most about these problems/symptoms?

_____

B. CURRENT GENERAL HEALTH AND STATUS:

Overall, my health is: ☐ Excellent ☐Very Good ☐Fair ☐Poor

Questions I have for the Doctor:

_____

_____

C. Patient profile:

☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Occupation: _____Since: _____ ☐Retired

D. Personal Social History

Do you currently smoke tobacco? ☐ Yes ☐ No
Do you currently chew or snuff tobacco? ☐ Yes ☐ No
_____ per day for _____ years
Have you ever smoked/chewed or snuffed? ☐ Yes ☐ No
What year did you quit tobacco? _____
Do you drink coffee, tea, or cola? ☐ Yes ☐ No
_____ per day
Do you consume alcohol? (beer, wine, liquor) ☐ Yes ☐ No
_____ drinks per week
Have you used street drugs? ☐ Yes ☐ No
Have you ever been treated for chemical dependency? ☐ Yes ☐ No
Have you ever been sexually abused? ☐ Yes ☐ No
Have you ever been physically abused? ☐ Yes ☐ No

E. Summary of Surgeries

Operation		Date
Hysterectomy	☐ Yes ☐ No	_____
Heart Surgery	_____	_____
Gallbladder	☐ Yes ☐ No	_____
Appendectomy	☐ Yes ☐ No	_____
Other_____		_____

F. Have you had any of the following examinations in the last 5 years?

Xrays		Year
Upper GI series (Barium)	☐ Yes ☐ No	_____
Lower GI series (Barium)	☐ Yes ☐ No	_____
Ultrasound	☐ Yes ☐ No	_____
CAT Scan chest/abd/pelvis	☐ Yes ☐ No	_____
Other: _____	☐ Yes ☐ No	_____
Endoscopy (SCOPE)		
Upper Endoscopy (EGD)	☐ Yes ☐ No	_____
Colonoscopy	☐ Yes ☐ No	_____
Sigmoidoscopy	☐ Yes ☐ No	_____

G. Family History

	Age, If Living	Health Status	or	Age, At Death	Cause of Death
Father	_____ ,	_____		_____ ,	_____
Mother	_____ ,	_____		_____ ,	_____
Brother	_____ ,	_____		_____ ,	_____
	_____ ,	_____		_____ ,	_____
	_____ ,	_____		_____ ,	_____
Sister	_____ ,	_____		_____ ,	_____
	_____ ,	_____		_____ ,	_____
	_____ ,	_____		_____ ,	_____

Disease	Relative
☐ Ulcer Disease	_____
☐ Liver Disease	_____
☐ Heart Disease	_____
☐ Colitis	_____
☐ Gallbladder Disease	_____
☐ Colon Cancer	_____
☐ Colon Polyps	_____
☐ Alcoholism	_____
☐ Cancer	_____
What type:	_____

Continued On Back

H. Medical Illnesses. Please place a check in any of the following you have had:

- ☐ Artificial Joints
- ☐ Low Blood Count (Anemia)
- ☐ High Cholesterol
- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Elevated Liver Enzymes
- ☐ Pancreatitis
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Colon Polyps
- ☐ Peptic Ulcer Disease
- ☐ Seizures
- ☐ Coronary Artery Disease
- ☐ Atrial Fibrilation
- ☐ Artificial Heart Valve
- ☐ Cardiac Stents
- ☐ Abnormal Heart Rhythm
- ☐ Congestive Heart Failure
- ☐ CABG (heart grafting)
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Thyroid Trouble
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Colitis
- ☐ Gallbladder Disease
- ☐ Tuberculosis
- ☐ HIV
- ☐ Pneumonia
- ☐ Bipolar Disease
- ☐ Schizophrenia
- ☐ Sleep Apnea
- ☐ Pacemaker
- ☐ Prior Heart Attack
- ☐ Mitral Valve Prolapse
- ☐ Defibrillator
- ☐ Cancer Type _____
- ☐ Blood Disease Type_____
- ☐ Other: _____
- ☐ Blood transfusions? Any reactions? _____

Do you require antibiotics prior to procedures? ☐ Yes ☐ No

FEMALE
Last Day of Last Period _____
Date of Last Pap Smear _____

I. Have you had any hospitalization in the last 5 years?
☐ Yes ☐ No

Findings/Diagnosis	Date
_____	_____
_____	_____

J. Allergies and Sensitivities to Drugs and Foods. List anything that you are allergic to including foods, medications or environmental allergens.

Allergic To:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

K. REVIEW OF SYSTEMS: (in the past month)

GENERAL/ENDOCRINE
Has your weight changed? ☐Lost _____ lbs.
☐Gained _____ lbs.

- ☐ Fever (recurrent or recent)
- ☐ Chills
- ☐ Excessive Thirst
- ☐ Heat Intolerance
- ☐ Cold Intolerance

SKIN
- ☐ Skin Problems Type _____

EYES, HEAD, NOSE, THROAT
- ☐ Worsening Vision
- ☐ Blurred Vision
- ☐ Sinus Infection
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Post Nasal Drip

CARDIOPULMONARY
- ☐ Chronic Cough
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ Swollen Ankles/Feet
- ☐ Shortness of Breath
- ☐ Recurrent Bronchitis
- ☐ Chest Pain
- ☐ Palpitations

DIGESTIVE
Has your appetite changed? ☐Increased ☐Decreased ☐Same

- ☐ Trouble Swallowing Food
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Vomiting of Blood
- ☐ Abdominal Pain
- ☐ Black Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Red Blood w/ Bowels
- ☐ Feeling full before finishing meals

Do you take any laxatives? ☐ Yes ☐ No

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Arthritis

HEMATOLOGIC/LYMPHATIC
- ☐ Recurrent Night Sweats
- ☐ Swollen Lymph Nodes
- ☐ Easy Bruising

NEUROLOGICAL
- ☐ Headaches
- ☐ Tremors
- ☐ Stroke / TIA

UROLOGICAL
- ☐ Painful Urination
- ☐ Blood In Urine
- ☐ Get up at night to void ____ times

PSYCHOSOCIAL
- ☐ Fainting spells
- ☐ Trouble sleeping
- ☐ Feeling tired or low energy
- ☐ Little interest or pleasure in doing things
- ☐ Depression
- ☐ Anxiety
- ☐ Worrying a lot

☐ I am willing to see any physician assistants associated with Gastroenterology Specialists for my initial consultation.

Additional Information for the doctor:

_____

_____

Patient's Signature _____