

# 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., aunt, 53 yr)

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?		