DIGESTIVE HEALTH CLINIC, LLC

MEDICAL HISTORY
DO NOT LEAVE BLANKS

Appointment Date _____

First Name _____ Middle Int. _____ Last Name _____ Birthdate ____/____/____ (Month/Day/Year) Sex _____

Describe the symptoms that led to your appointment: _____

When did the symptoms begin? _____ Primary Care Physician: _____ (First and Last Name)

Your Past Medical History: Have you had any of the following?

GASTROINTESTINAL	No	Yes
Barrett's esophagus	○	○
Ulcers, stomach or duodenum	○	○
Colon or Rectal polyps	○	○
Crohn's disease	○	○
Diverticulitis	○	○
Diverticulosis	○	○
Irritable bowel syndrome	○	○
Ischemic colitis	○	○
Ulcerative colitis	○	○
Have you ever had blood found in a stool test?	○	○
Cirrhosis	○	○
Hemochromatosis	○	○
Liver disease, Jaundice	○	○
Viral hepatitis	○	○

CARDIOVASCULAR	No	Yes
Anemia	○	○
Atrial fibrillation	○	○
Heart attack	○	○
High triglycerides/cholesterol	○	○
Heart valve replaced (If yes, date of surgery) _____		
Pacemaker/Defibrillator (If yes, date of surgery) _____		

RESPIRATORY	No	Yes
Asthma	○	○
COPD	○	○

CANCER	No	Yes
Stomach	○	○
Colon / Rectal	○	○
Breast	○	○
Ovarian	○	○
Uterine	○	○
Other (Type) _____	○	○

GENERAL

	No	Yes		No	Yes
Arthritis	○	○	Seizure, Epilepsy	○	○
Depression	○	○	Stroke	○	○
Diabetes	○	○	Thyroid disorder	○	○
Kidney disease	○	○	Vascular graft	○	○

SURGERIES	No	Yes	If yes, date, type of surgery/procedure and location
Have you had any surgeries in the last year?	○	○	
Have you been hospitalized in the last year?	○	○	
Have you had a CT, MRI or Ultrasound in the last year?	○	○	
Gallstones removed	○	○	
Gallbladder has been removed	○	○	
Appendix has been removed	○	○	
Have you had a colectomy?	○	○	
Have you ever had a colonoscopy?	○	○	
Have you ever had a sigmoidoscopy (flex sig)?	○	○	
Have you ever had an EGD (upper endoscopy)?	○	○	
Have you had a hysterectomy?	○	○	

First Name Middle Int. Last Name

____/____/____
Month Day Year
Birthdate

Allergies & Sensitivities:
(tape, latex, medications, and food) ☒ **None**

Allergy	Reaction
Sensitivity	

Family Medical History (blood relatives):
Check the box for conditions that apply. ☐ **None** ☐ **Adopted**

Condition	Parents Mother/Father		Siblings Sister/Brother		Children Daughter/Son	
Colon/Rectal polyps	☐	☐	☐	☐	☐	☐
Colon/Rectal cancer	☐	☐	☐	☐	☐	☐
Pancreatic cancer	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐
Cirrhosis	☐	☐	☐	☐	☐	☐
Crohn's disease	☐	☐	☐	☐	☐	☐
Gallstones	☐	☐	☐	☐	☐	☐
Ulcerative colitis	☐	☐	☐	☐	☐	☐

Vaccinations: Have you received any of the following? ☐ **None**

Vaccine	Date received
Hepatitis A	
Hepatitis B	
Pneumonia	
Influenza	
Shingles (Zostavax)	

Blood thinners: Are you taking any of the following blood thinners? ☐ **None**

Medication	No	Yes
Aspirin	◉	○
Coumadin (warfarin)	○	○
Eliquis	○	○
Plavix	○	○
Pradaxa	○	○
Xarelto	○	○

Medications (including over the counter dietary supplements and prescription) ☒ **None**

Name and location of your preferred pharmacy: _____

Medication	Dose	How often do you take?	Do you need a refill?

First Name Middle Int. Last Name

____/____/____
Month Day Year
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Personal Habits: Circle the answers that best apply to you.

Which best describes your use of tobacco products? never / in the past / currently

If you currently use or have formerly used tobacco, what type? chew / cigar / cigarette / pipe / snuff / other

Which best describes your alcohol consumption? never / in the past / currently

If you currently or have formerly consumed alcohol, what type? beer / wine / liquor

If you currently drink alcohol, how often? daily / weekly / monthly / occasionally

What is the average number of drinks you have when drinking? (write in number) _____

When was your last drink? _____

What is your marital status? (circle one) married / partner / separated / divorced / single / widow

What is your occupation? _____

Recent Symptoms (Within last 30 days)

CONSTITUTIONAL	No	Yes
chills, fevers, sweats		
weight loss		

EYES	No	Yes
change in vision		

EARS/NOSE/THROAT	No	Yes
lump in throat		
drainage back of throat		

RESPIRATORY	No	Yes
persistent cough		
shortness of breath		

CARDIOVASCULAR	No	Yes
pain, pressure in chest		
swelling in feet or ankles		
irregular or rapid heart		

GASTROINTESTINAL	No	Yes
difficulty swallowing		
red rectal bleeding		
black stools		
diarrhea		
constipation		
recent change in bowels		
abdominal pain		
nausea		
vomiting		
heartburn		

GENITOURINARY	No	Yes
burning urination		
frequent urination		
passed blood in urine		

WOMEN ONLY	No	Yes
abnormal menstrual periods		

BE SURE TO TELL US IF YOU ARE PREGNANT OR BECOME PREGNANT.

NERVOUS SYSTEM	No	Yes
frequent headaches		
loss of strength		

PSYCHIATRIC	No	Yes
anxiety		
depression		

SKIN	No	Yes
skin rashes		
itching		

MUSCULOLSKELETAL	No	Yes
joint pain or stiffness		
back pain		

Other Medical Problems Not listed

_____

_____

_____

_____

_____

_____ ____/____/____

Patient/Representative Signature Today's Date