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 (tape, latex, medications, and food)
☐ **None**

Allergy	Reaction

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 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
Birthdate

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