DIGESTIVE CARE & MANAGEMENT

Medical History Form

Today's Date_____ **Date of Birth**_____

Name_____ **Height**_____

Referring Provider_____ **Primary Care Provider**_____

☐Reflux ☐Abdominal Pain ☐Irregular Heart Beat/Arrhythmia ☐Seizures
☐Barretts Esophagus ☐Cirrhosis ☐High Cholesterol or Triglycerides ☐Tremors
☐Esophageal Stricture ☐Hepatitis B ☐Fibromyalgia ☐HIV/AIDS
☐Stomach/ Duodenal Ulcer ☐Hepatitis C ☐Tuberculosis (TB) ☐Glaucoma
☐Irritable Bowel (IBS) ☐Fatty Liver ☐Arthritis ☐Anxiety/Depression
☐Diverticulosis/Diverticulitis ☐Anemia ☐Asthma ☐Sleep Apnea ☐C-PAP
☐Crohn's Disease ☐Hemochromatosis ☐Chronic Lung Disease/Emphysema ☐Cancer_____
☐Ulcerative Colitis ☐High Blood Pressure ☐Diabetes ☐Radiation Treatment
☐Colon Polyps ☐Valvular Heart Disease ☐Thyroid Disease ☐Blood Transfusion
☐Colon Cancer ☐Coronary Artery Disease ☐Kidney Disease Year_____
☐Celiac Disease ☐Heart Attack ☐Stroke/TIA ☐Other_____

☐Appendectomy ☐Cardiac Surgery ☐Stomach or Ulcer Surgery ☐Small Bowel Resection
☐Gallbladder ☐Hemorrhoids ☐Colon Resection ☐Other_____
☐Wt.Loss/Gastric By-pass ☐Hernia ☐Hiatal Hernia Repair (fundoplication)
_____
☐Hysterectomy (partial or complete)
☐EGD (upper endoscopy) Date:_____ GI Physician:_____ Findings:_____
☐Colonoscopy Date:_____ GI Physician:_____ Findings:_____

Family Life	**Alcohol consumption**	**Tobacco Use**	**Drug Use**
☐Single	☐I do not drink Alcohol	☐never smoked or < 100 in lifetime	☐Never used illegal drugs
☐Married	☐I drink < 3 drinks of alcohol weekly	☐Non-smoker (previous smoker)	☐Past history of drug use
☐Widowed	☐I drink > 3 drinks of alcohol weekly	☐Few (1-3) cigarettes per day	☐Type_____
☐Separated	☐I drink 2 or more drinks daily	☐Up to 1 pack per day	☐Current use of drugs
☐Divorced	☐I have a history of alcohol abuse	☐1-2 packs per day	☐Type_____
		☐2 or more packs per day	

☐Unknown or Adopted ☐I have no Family History of Colon Cancer, Colon Polyps, or Inflammatory Bowel Disease

☐Colon Cancer Who:_____ Age Diagnosed:_____

☐Colon Polyps Who:_____ Age Diagnosed:_____

☐Esophageal Cancer ☐Stomach Cancer ☐Liver Cancer ☐Celiac Disease ☐Crohn's or Ulcerative Colitis

Medical History Form

Do you currently have any of the following symptoms?

Gastrointestinal

☐Heartburn
☐Trouble Swallowing
☐Nausea
☐Vomiting
☐Abdominal Pain
☐Bloating
☐Flatulence
☐Diarrhea
☐Constipation
☐Pain with BMs
☐Blood in Stools
☐Dark/Black Stools
☐Poor Appetite
☐Jaundice

Constitutional

☐Fatigue
☐Fever
☐Chills
☐Headache
☐Night Sweats
☐Unexplained Weight Loss

Eyes

☐Blindness
☐Eye pain
☐Change in vision

Skin

☐Rash
☐Color Change
☐Itching

Ears, Nose, and Throat

☐Decreased Hearing
☐Mouth Ulcers
☐Sore Throat
☐Hoarseness

Cardiovascular

☐Chest Pain
☐Heart Murmur
☐Palpitation/Fluttering
☐ Fast/Slow Heart Beat

Respiratory

☐Shortness of Breath
☐Asthma/Wheezing
☐Cough

Genitourinary

☐Painful Urination
☐Urinary Frequency
☐Blood in Urine

Gynecology

☐Abnormal Menstrual Cycles
☐Pelvic Pain/Cramping
☐Breast Pain/Discharge
☐Is there any chance you could be pregnant?

Musculoskeletal

☐Back Pain
☐Joint Pain/Arthritis
☐Muscle Pain/Weakness

Neurological

☐Loss of Consciousness
☐Seizures/Convulsions
☐Headaches
☐Dizziness

Endocrine

☐Cold/Heat Intolerance
☐Dry Skin
☐Hair Loss
☐Always Thirsty

Psychiatric

☐Depression
☐Anxiety
☐Panic Disorder
☐Personality Disorder

Hematologic/Lymphatic

☐Easy Bruising
☐Bleeding Tendencies
☐Blood Clotting Problem
☐Enlarged Lymph Glands

Allergic/Immunologic

☐Seasonal Allergies
☐Year-round Allergies
☐Food Allergies
☐Problems with Immune System

MEDICAL ALLERGIES ☐**I do not have any medication allergies**

☐Latex_____ ☐Iodine_____ ☐IV Contrast_____ ☐Anesthetic_____ ☐Bee Sting_____

List medication and place number(s) of the allergic reaction experienced from the legend below along with a letter that best describes the severity of the reaction.

Medication Allergy	*Number/Letter*	*Medication Allergy*	*Number/Letter*
1._____	_____	**2.**_____	_____
3._____	_____	**4.**_____	_____
5._____	_____	**6.**_____	_____
7._____	_____	**8.**_____	_____

Skin	Local	Abdominal	Systemic/Anaphylactic
1. Rash (localized)	**7. Conjunctivitis**	**10. Pain/Cramping**	**14. Shortness-of-Breath**
2. Rash (generalized)	**8. Runny Nose**	**11. Bloating/Gas**	**15. Tongue Swelling**

3. Itchiness
4. Patchy Swelling/Skin
5. Facial Swelling
6. Hives
9. Cough
12. Nausea/ Vomiting
13. Diarrhea
16. Difficulty Speaking/Swallowing
17. Dizziness/Lightheadedness
18. Loss of Consciousness
19. Chest Pain
20. Irregular Heart Beat
21. Rapid/Slow Heart Rate
22. Respiratory Distress

Severity: (A) Very Mild (B) Mild (C) Moderate (D) Severe

Use back of form if needed.

Medical History Form

Current Medication – List ALL medications you are currently taking: prescription, over-the-counter, vitamins, supplements, and those taken only as needed.

Medications	Dose	How Many Times Daily?

Pharmacy Information

Do you have a preferred pharmacy? ☐No ☐Yes Pharmacy Name_____

Pharmacy Address, City, State, Phone number if known_____