GASTROENTEROLOGY CONSULTANTS, P.A.

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HEALTH HISTORY

TODAY'S DATE:____________

PATIENT NAME: __________________________ BIRTHDATE: _____________ PATIENT #:__________

To help us meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

Place of birth:________________________________
Occupation:__________________________________
When was your last physical exam?_______________
Name of Doctor____________Phone#_____________
Please list all medications you are currently taking (include non-prescription drugs): none ☐
____
____
____
Allergies:____________________________________

Describe all serious accidents, severe injuries, head injuries, fractures or broken bones. List all serious illnesses, operations, and other hospitalizations.(include year occurred): none ☐
____
____

Exercise: Yes☐No☐If yes, how much______________
Smoke: Yes☐No☐ If yes, how much______________
Drink: Yes☐No☐ If yes, how much______________
Drugs: Yes☐No☐If yes, how much______________

Chief Complaints: Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

____
____
____

Past Medical History: Have you ever had the following: (Select "no" or "yes", or leave blank if you are uncertain)

Heart Disease	Yes☐	No☐	Arthritis	Yes☐	No☐	Hemorrhoids	Yes☐	No☐
Asthma/COPD	Yes☐	No☐	Venereal Disease	Yes☐	No☐	AIDS or HIV+	Yes☐	No☐
Diabetes	Yes☐	No☐	Mitral Valve Prolapse	Yes☐	No☐	Hepatitis	Yes☐	No☐
Neurological Disease	Yes☐	No☐	Ulcer	Yes☐	No☐	Kidney Disease	Yes☐	No☐
High Blood Pressure	Yes☐	No☐	Glaucoma	Yes☐	No☐	Sleep Apnea	Yes☐	No☐
Tuberculosis	Yes☐	No☐	Anemia	Yes☐	No☐	Cancer	Yes☐	No☐
Rheumatic Fever	Yes☐	No☐	Skin Disease	Yes☐	No☐	Anxiety	Yes☐	No☐
Stroke	Yes☐	No☐	High Cholesterol	Yes☐	No☐	Depression	Yes☐	No☐
Thyroid Disease	Yes☐	No☐	Epilepsy	Yes☐	No☐	Other____________________		

Family History: Has any blood relative had cancer? Yes☐No☐ **If yes**, relationship/type cancer________________
Please provide present age, or age of death for below. If living, health (good, fair, poor) If deceased, cause of death.

Father ________________________________
Mother ________________________________
Siblings________________________________
Spouse________________________________
Children________________________________
____

Do you have now or have you had within the past year: (Select "no" or "yes", or leave blank if you are uncertain)

Tire easily or weakness	Yes☐	No☐	Heartburn	Yes☐	No☐	Chronic constipation	Yes☐	No☐
Recent weight changes	Yes☐	No☐	Frequent belching	Yes☐	No☐	Rectal bleeding	Yes☐	No☐
Change in appetite	Yes☐	No☐	Nausea	Yes☐	No☐	Black tarry stools	Yes☐	No☐
Chest pain or discomfort	Yes☐	No☐	Vomiting	Yes☐	No☐	Dark urine	Yes☐	No☐
Chronic or frequent cough	Yes☐	No☐	Abdominal cramping	Yes☐	No☐	Frequent urination	Yes☐	No☐
Vomited/coughed up blood	Yes☐	No☐	Yellow jaundice	Yes☐	No☐	Chronic diarrhea	Yes☐	No☐
Difficulty swallowing	Yes☐	No☐	Sore throat	Yes☐	No☐	Other symptoms______________		

X__________________________________ ________________________
Signature of patient or parent, if minor **Date**