

DIGESTIVE DISEASE ASSOCIATES MEDICAL HISTORY FORM

Date: _____

Patient Name: _____ DOB: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

Reason for visit: _____

Gastrointestinal Problems (please check all that apply)

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Abnormal liver blood tests	<input type="checkbox"/> Black, tarry stools
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Constipation	<input type="checkbox"/> Vomiting blood
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Incontinence of stool
<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Regurgitation
<input type="checkbox"/> Bloating	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> History of hepatitis Type _____
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Abnormal abdominal CT scan or ultrasound

Have you ever had any of the following tests? Circle all that apply and indicate date

Upper GI Series	Date: _____	Upper Endoscopy	Date: _____
Barium Enema	Date: _____	Flexible Sigmoidoscopy	Date: _____
Colonoscopy	Date: _____	Ultrasound (abdomen)	Date: _____

Grey Box for Physician Use only

PAST MEDICAL ILLNESSES (Please check any medical conditions you have been diagnosed with)

Gastrointestinal

<input type="checkbox"/> Heartburn/GERD	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Anal Fistula
<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Fatty Liver
<input type="checkbox"/> Gastritis	<input type="checkbox"/> Irritable bowel (IBS)	<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> H. Pylori	<input type="checkbox"/> Spastic Colitis	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Ulcer	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Diverticulosis/itis	<input type="checkbox"/> Anal Fissure	

Cardiovascular

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Angina	<input type="checkbox"/> PVC's (extra heart beats)		

Pulmonary

<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sarcoidosis	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Emphysema (COPD)	<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Lung Cancer	

Neuropsychiatric

<input type="checkbox"/> Stroke	<input type="checkbox"/> Migraines	<input type="checkbox"/> Dementia	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> TIA (mini-stroke)	<input type="checkbox"/> Chronic Headaches	<input type="checkbox"/> Depression	<input type="checkbox"/> ADHD
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Seizures	<input type="checkbox"/> Myasthenia gravis	<input type="checkbox"/> Bipolar Disorder	

Hematologic

<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Hodgkin's Disease	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Hemochromatosis	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Myelodysplasia

Endocrine

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pituitary Problem
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Thyroid Nodule	<input type="checkbox"/> Thyroid Cancer	<input type="checkbox"/> Adrenal Problem

Genitourinary

<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Ovarian (Cyst(s))	<input type="checkbox"/> Abnormal PAP smears
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Bladder Incontinence	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Cone Biopsy/LEEP
<input type="checkbox"/> Kidney Tumors/Cysts	<input type="checkbox"/> Prostate Hypertrophy	<input type="checkbox"/> Uterine Fibroids	<input type="checkbox"/> Cervical Cancer
<input type="checkbox"/> Bladder Cancer	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> Endometriosis

Breast

<input type="checkbox"/> Fibrocystic Breast Changes	<input type="checkbox"/> Breast Cancer (left or right)		
---	--	--	--

Musculoskeletal

<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Lupus
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Osteopenia	<input type="checkbox"/> Polymyalgia Rheumatica	<input type="checkbox"/> Gout

Eyes, Ears, Nose and Throat

<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Allergic Rhinitis	<input type="checkbox"/> Oral Thrush
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Sjogren's (dry eyes)

Dermatologic

<input type="checkbox"/> Eczema	<input type="checkbox"/> Vitiligo	<input type="checkbox"/> Raynaud's Syndrome	<input type="checkbox"/> Melanoma
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Alopecia	<input type="checkbox"/> Skin Cancer	

Oncologic

<input type="checkbox"/> Any other surgical tumors not mentioned
--

Surgical History (list all surgeries and procedures)**Date**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies or Reactions to Medications to Include Over-the Counter (please list all)

() I do not have any allergies or reactions to medications to include over-the counter

Are you allergic to latex? (circle yes or no) Yes No

Are you allergic to Iodine or IV Contrast dye? (circle yes or no) Yes No

Please review the following statements and check, where applicable

<input type="checkbox"/> I have had prior difficulties with anesthesia	<input type="checkbox"/> I have a pacemaker
<input type="checkbox"/> I have sleep apnea	<input type="checkbox"/> I Use a CPAP device
<input type="checkbox"/> I have a defibrillator	<input type="checkbox"/> I have a cardiac stent
<input type="checkbox"/> I am on a blood thinner	<input type="checkbox"/> I have an artificial valve
<input type="checkbox"/> I take non-steroidal medications (ie. Motrin, Aleve, Advil, etc.)	<input type="checkbox"/> I have had a blood transfusion

Medications (list all prescription and “over-the-counter” medications)

FAMILY HISTORY

Do any of your family members have these diseases? (If so, indicate family member)

	<u>Relationship</u>		<u>Relationship</u>
Colon Cancer	_____	Uterine Cancer	_____
Crohn’s Disease	_____	Kidney Cancer	_____
Ulcerative Colitis	_____	Breast Cancer	_____
Celiac Disease	_____	Thyroid Cancer	_____
Stomach Cancer	_____	Liver Cancer	_____
Pancreatic Cancer	_____	Colon Polyps	_____
Ovarian Cancer	_____		

SOCIAL HISTORY

Marital status: ___Single ___Married ___Separated ___Divorced ___Widowed

Occupation: _____

Tobacco use (Circle one)? Use tobacco Do not use tobacco Do not use tobacco but did in the past

Type of tobacco (cigarettes, cigars, chewing tobacco): _____

Frequency (packs, # of cigars, amount of chewing tobacco, per day): _____

If you use tobacco, for how many years?: _____ years

If you do not use tobacco but did in the past,

When did you quit? _____ What type of tobacco did you use? _____

What was your frequency?: _____ How many years did you use tobacco?: _____ yrs

Alcohol use (Circle one): Consume alcohol Do not consume alcohol Do not consume alcohol but did in past

If you consume alcohol, please circle all of the following which apply: wine mixed drinks beer

If you consume alcohol, please indicate amount of wine, mixed drinks or beer (in glasses, bottles or cans) ___ per day ___ per week

Caffeine Use (circle one) Consume caffeine Do not consume caffeine

___ Number of cups per day of caffeinated coffee? ___ Number of cups per day of caffeinated tea?

___ Number of glasses/cans/bottles per day of caffeinated soda?

REVIEW OF SYSTEMS (please check all conditions which may apply)

Constitutional

<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue
--------------------------------------	--------------------------------------	--------------------------------	----------------------------------

Eyes/Ears/Nose/Mouth/Throat

<input type="checkbox"/> Vision loss	<input type="checkbox"/> Double vision	<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Ringing in ears

Cardiovascular

<input type="checkbox"/> Chest pain, pressure or tightness	<input type="checkbox"/> Palpitations (irregular heartbeat)	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Ankle swelling
--	---	---------------------------------------	---

Respiratory

<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Cough	<input type="checkbox"/> Phlegm
--	--------------------------------	---------------------------------

Genitourinary

<input type="checkbox"/> Painful urination	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Frequent urination
--	---	---

Musculoskeletal

<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Joint pain or arthritis
--------------------------------------	--	--

Integumentary (skin/breast)

<input type="checkbox"/> Rashes	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Breast mass
<input type="checkbox"/> Breast pain	<input type="checkbox"/> Nipple discharge	

Neurological

<input type="checkbox"/> Headaches	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Weakness
<input type="checkbox"/> Numbness or tingling	<input type="checkbox"/> Nerve injury	<input type="checkbox"/> Coordination problems

Endocrine

<input type="checkbox"/> Heat and/or cold intolerance	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Excessive urination
---	---	--

Hematalogic/Lymphatic

<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> Platelet disorders	<input type="checkbox"/> Enlarged lymph glands
--	--	---	--

PLEASE SIGN AND DATE

Patient Signature

Date

Grey box for physician use only

Reviewed by (provider signature): _____ Date reviewed: _____
