MEDICAL HISTORY

Patient Name:

Today's Date

Month Day Year

Date of Appointment

Month Day Year

Weight:

Height:

Gender:

Age:

Race:

Language:

Marital Status:

Ethnicity:

How did you hear about us?

Please Check Any That Apply.

IDENTIFY THE MAIN REASON FOR THE VISIT

- ☐ EXAMPLES: Abnormal Labs
- ☐ Abnormal X-Ray
- ☐ Check-Up
- ☐ Drug Monitoring/Therapeutic Monitoring
- ☐ Follow-Up of Previously Identified Problems
- ☐ General Follow-Up
- ☐ Digestive Symptoms – Abdominal Pain
- ☐ Acidic Stomach Altered Bowl Habit
- ☐ Bloating/Gas
- ☐ Constipation
- ☐ Dark Urine
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Feeding Difficulties
- ☐ Food Intolerance
- ☐ Heartburn
- ☐ "Indigestion"
- ☐ Irregular Bowl Movements
- ☐ Lack of Appetite,
- ☐ Nausea/ Vomiting
- ☐ Need for Laxatives
- ☐ Rectal Bleeding
- ☐ Weight Loss/Weight Gain
- ☐ Non-Digestive Symptoms – Back Pain
- ☐ Chest Pain
- ☐ Extremity and Joint Pain
- ☐ Headache
- ☐ Influenza
- ☐ Respiratory Symptoms
- ☐ Other

Comments:

Any allergies or side-effects of medications?

- ○ Yes
- ○ No

Any allergies or side-effects to anesthesia?

- ○ Yes
- ○ No

Any allergies or side-effects to supplements?

- ○ Yes
- ○ No

Any allergies or side-effects to latex?

- ○ Yes
- ○ No

Latex Allergy?

○ Y ○ N

Do You Take Aspirin?

○ Y ○ N

Do you have any known drug allergies?

○ Y ○ N

Please list any allergies you have

What is your height?

What is your weight without clothes?

Additional height and weight comments

PAST MEDICAL HISTORY:

☐ Acid Reflux ☐ Asthma ☐ Bleeding Problems ☐ Blood Transfusions ☐ Cancer ☐ Convulsions

☐ Crohns/ Colitis ☐ Depression ☐ Diverticulitis ☐ Diabetes Mellitus ☐ Epilepsy ☐ Gout

☐ High Blood Pressure ☐ Heart Attack ☐ Heart Disease ☐ Hemorrhoids ☐ Hepatitis ☐ IBS ☐ Jaundice

☐ Kidney Stones ☐ Kidney/Bladder Infections ☐ Liver Disease

☐ Nervous Breakdown Requiring Formal Psychiatric Evaluation ☐ Peptic Ulcer Disease ☐ Seizure Disorder

☐ Sleep Disorder/Apnea ☐ Stroke ☐ Thyroid disease ☐ TB

Comments:

PAST SURGICAL HISTORY:

☐ Abdominal ☐ Appendix ☐ Breast ☐ Cancer ☐ Cosmetic ☐ Foot ☐ Gallbladder ☐ Heart ☐ Hemorrhoids

☐ Hernia ☐ Hysterectomy ☐ Polyp Removal ☐ Removal of Ovaries ☐ Skin ☐ Tonsillectomy ☐ Ulcer

☐ Varicose Veins ☐ GI: Capsule Endoscopy ☐ Colonoscopy ☐ Endoscopy ☐ Endoscopic Ultrasound

☐ ERCP ☐ Liver Biopsy ☐ Other

FAMILY HISTORY:

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Ulcer

SOCIAL HISTORY:

○ Single ○ Married ○ Widowed ○ Divorced

Number of Children:

# of Yrs?

Smoking History:

Y N

Per Day?

Alcohol Consumption:

Y N

day, wk, mo

# of Yrs?

Recreational Drug Use:

Y N

day, wk, mo, yr

Coffee/Tea:

Y N

Medication And Supplements

Patient Name:

Primary Physician:

Allergies:

Pharmacy:

Ph:

	Medications / Sig.	Dates	Reviewed	and	Updated	Comments
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