MEDICAL HISTORY

Patient Name: ______________________________ Age ______ Date of Print: _________

Please Circle Any That Apply.

IDENTIFY THE MAIN REASON FOR THE VISIT

EXAMPLES: **A**bnormal Labs, Abnormal X-Ray, **C**heck-Up, **D**rug Monitoring/Therapeutic Monitoring, **F**ollow-Up of Previously Identified Problems, **G**eneral Follow-Up,

Digestive Symptoms – (**A**bdominal Pain, Acidic Stomach Altered Bowl Habits, **B**loating/Gas, **C**onstipation, **D**ark Urine, Diarrhea, Difficulty Swallowing, **F**eeding Difficulties, Food Intolerance, **H**eartburn, "**I**ndigestion", Irregular Bowl Movements, **L**ack of Appetite, **N**ausea/ Vomiting, Need for Laxatives, **R**ectal Bleeding, **W**eight Loss/Weight Gain)

Non-Digestive Symptoms – (Back Pain, Chest Pain, Extremity and Joint Pain, Headache, Influenza, Respiratory Symptoms, Other)

ANY ALLERGIES OR SIDE-EFFECTS OF MEDICATIONS OR ANESTHESIA? Yes / No

Latex Allergy?: Yes / No **Aspirin Use**: Yes / No

PAST MEDICAL HISTORY: - **A**cid Reflux, Asthma, **B**leeding Problems, Blood Transfusions, **C**ancer, Convulsions, Crohns/ Colitis, **D**epression, Diverticulitis, Diabetes Mellitus, **E**pilepsy, **G**out, **H**igh Blood Pressure, Heart Attack, Heart Disease, Hemorrhoids, Hepatitis, **I**BS, **J**aundice, **K**idney Stones, Kidney/Bladder Infections, **L**iver Disease, Nervous Breakdown-Requiring Formal Psychiatric Evaluation, **P**eptic Ulcer Disease, **S**eizure Disorder, Sleep Disorder/ Apnea, Stroke, **T**hyroid disease, **T**B,

Comments:

PAST SURGICAL HISTORY: – **A**bdominal, Appendix, **B**reast, **C**ancer, Cosmetic, **F**oot, **G**allbladder, **H**eart, Hemorrhoids, Hernia, Hysterectomy, **P**olyp Removal, **R**emoval of Ovaries, **S**kin, **T**onsillectomy, **U**lcer, **V**aricose Veins, **GI: C**apsule Endoscopy, Colonoscopy, **E**ndoscopy, Endoscopic Ultrasound, ERCP, **L**iver Biopsy, Other:

FAMILY HISTORY: - Cancer, Diabetes, Heart Disease, High Blood Pressure, Ulcer

SOCIAL HISTORY: – Single, Married, Widowed, Divorced, Number of Children: ____ Smoking History: Y. N. # of Yrs? ____Per Day? ____ Alcohol Consumption: Y. N. ___day, wk, mo # of Yrs?____

Recreational **Eyes** Drug Use: Y.N. Coffee/Tea: ___ day, wk,

Obtained by: ________________ Reviewed by Physician: _______________________ **Date of Appointment_________**

ALL CURRENT MEDICATIONS AND SUPPLEMENTS

Patient Name: ______________________________ **Primary Physician:** ________________ **Date:**__________

Allergies: ____ **Pharmacy:**_____________ **Ph:** ___________

Medications / Supplements.	Dosage	Frequency	Start Date	Comments