

MEDICAL HISTORY

NAME: _____

DATE: _____

AGE: _____

PRIMARY OR REFERRING DOCTOR: _____

REASON FOR CONSULTATION: _____

ADDITIONAL MEDICAL PROBLEMS: (Check those which apply)

High Blood Pressure _____

Diabetes Mellitus _____

Asthma, Emphysema _____

High Cholesterol _____

Stroke or TIA _____

Thyroid Problems _____

Arthritis _____

Seizures _____

Heart Disease: Heart Attack _____

Congestive Heart Failure _____

Arrhythmia _____

Murmur _____

Cancer (if so, what type and when) _____

Depression, Anxiety, or Psychiatric Illness _____

Any other illness or medical condition not mentioned above _____

PRIOR SURGERY: (Type of surgery and approximate year—most recent first if possible)

1. _____

2. _____

3. _____

4. _____

5. _____

CURRENT MEDICATIONS: (Names only—doses not necessary)

_____	_____
_____	_____
_____	_____
_____	_____

DRUG ALLERGIES: _____

SOCIAL HISTORY: Do you smoke? _____ If so, how much per day? _____

Do you drink alcohol, including wine or beer? _____

If so, how much do you drink per week? _____

Occupation: _____

Marital status: (circle) S M D W Other: _____

FAMILY HISTORY: (Immediate family members only)

Of colon cancer or polyps? _____

Of liver disease? _____

Of stomach, esophageal, or pancreatic cancer? _____

JUST A FEW MORE QUESTIONS:

1. Do you take aspirin, anti-inflammatory pain relievers, or arthritis medications, other than Tylenol? _____ If so, which ones and approximately how often? _____

2. Have you had any recent tests (bloodwork, scans, or x-rays) that you believe would help us in your care? _____ If so, please ask your doctor to fax them to us (863-1234) and inform our office staff upon your arrival.

3. Have you seen another gastroenterologist before? _____
If so, please inform the office staff of this doctor's name and when you most recently saw them.