

MR#: _____

Date of Birth _____ Last Name: _____

First Name, Middle Initial: _____ Primary Care Physician: _____

FOR OFFICE STAFF ONLY. PLEASE DO NOT WRITE IN BOX BELOW.

Nuse/Doctor notes:

Tests or labs ordered today:

Have you been diagnosed with any of these issues? Currently or in the past.

CARDIAC	Yes	No	Year	NEUROLOGIC	Yes	No	Year
High blood pressure				Seizures			
Low blood pressure				Weakness			
Irregular heartbeat				Migraines			
Chest pain				Previous stroke			
High cholesterol				MUSCULOSKELETAL			
Vascular Disease				Muscle disease			
Pacemaker				Arthritis			
RESPIRATORY				Neck pain			
Asthma				Back pain			
Pneumonia				Blood disorder			
Bronchitis				Rash			
Chronic cough				MRSA			
Hoarseness				Bruises			
Tracheostomy				OPHTHALMIC			
COPD				Blindness			
Tuberculosis				Cataracts			
GENITOURINARY				Glaucoma			
Kidney disease				PSYCHOSOCIAL			
Chronic renal failure				Alcoholism			
Dialysis				Substance abuse			
Urine infection (UTI)				Depression			
ENDOCRINE/METABOLIC				Anxiety disorders			
Diabetes TYPE I or II				CANCER? Please list below:			
Thyroid disorder							

Have you experienced any of the following gastrointestinal and hepatic symptoms recently?

Symptom/Illness	Today	Frequency in the past 2 months	Indicate if this issue is resolved or if not, please elaborate
Diarrhea			
Constipation			
Rectal bleeding			
Change in bowel habits			
Weight loss			
Dark stools			
Irritable bowel			
Crohn's disease			
Ulcerative colitis			
Ulcerative colitis			
Trouble swallowing			
Nausea/Vomiting			
Heartburn			
Abdominal pain			
End-stage liver disease			
Cirrhosis			
Hepatitis			
Pancreatitis			
ACUTE/CHRONIC			

Past gastrointestinal procedures:	Yes	No	Approximate date	Were polyps found?	Any abnormal findings? Please explain
Colonoscopy?					
Upper endoscopy? (EGD)					
Have you:					
Had a blood transfusion?					
Donated blood?					
Tattoos? (year of oldest tattoo?)					
Have you ever had surgery or been hospitalized?					
Problems with anesthesia?					

Social history	Alcohol: How many drinks per day? _____ Per week? _____ Per month? _____ Do you currently use street drugs? Yes _____ No _____ If yes, how often? _____ Have you ever used street drugs? Yes _____ No _____ Last use? _____
Tobacco use Please check one: • Non-Smoker _____ • Current smoker _____ • Former Smoker _____	Tobacco: How many packs per day? _____ For how many years? _____ At what age did you begin Smoking? _____ Year quit? _____

Please list any allergies, including environmental, medication, food, and any reactions to previous blood transfusion:

Family history:

Condition	Relation	Living/deceased?	Condition	Relation	Living/ deceased?
Colon/Rectal Cancer No _____ Yes _____			Kidney problems No _____ Yes _____		
Stomach cancer No _____ Yes _____			Ulcerative colitis No _____ Yes _____		
Breast cancer No _____ Yes _____			Heart disease No _____ Yes _____		
Crohn's disease No _____ Yes _____			Bleeding problems No _____ Yes _____		
Ovarian cancer No _____ Yes _____					

Please indicate in this section any issues we have not addressed on this form:

Patients: please do not sign until the Medical Assistant has gone over this information with you

I _____ agree that the information I have provided on this patient history form is accurate to the best of my knowledge. The Medical Assistant has reviewed the information with me in the room, and I agree that this information will become part of my permanent medical record.

Patient Signature

Date

FOR OFFICE USE ONLY. PATIENTS, PLEASE DO NOT WRITE BELOW THIS LINE.

The above information has been reviewed/discussed with the patient. No _____ Yes _____

Date reviewed _____ Staff name/Title _____ Signature _____

Patient refused? No _____ Yes _____ If refused, reason: _____