Digestive Health Center New Patient Gastroenterology History Form

Today's Date:_____/_____/_____ First Name _____ MI ____ Last _____ SS#_____-____-_____

Date of Birth ____/_____/_____ Sex: Male Female Marital Status _____Occupation _____

Referring Physician _____ Primary Physician_____

CHIEF COMPLAINT & PRESENT ILLNESS

List All Symptoms _____*If Symptom(s) Includes PAIN, Please Circle All That Best Describe Your Pain:* Aching

Burning Continuous Cramping Deep Dull Gnawing Gradual Intermittent

Mild Moderate Periodic Sharp Shifting Stabbing Sudden Superficial Other **_____**

Duration _____ Years _____ Months _____ Weeks _____ Days ____ Other _____

Location of pain: RT Upper | RT Lower | LT Upper | LT Lower | Middle Date Symptom(s) Began _____

Frequency of Symptom(s) __ x per Day| Month| Year- Constant Intermittent Occasional Rare Recurrent Other _____

Intensity of Symptom (s) Excruciating Improving Mild Moderate Severe Other _____

How Did Symptom(s)Start _____How Did Symptom(s) Progress _____

What Brings It On_____ What Makes It Worse _____

What Relieves It _____ Associated Symptom(s) _____

Have you recently (in the past year) taken any Antibiotics? Yes No If so, when and which antibiotics? _____

MEDICATIONS

List All Medications You Are Currently Taking. Include ALL Medications Even Over-The-Counter Products.

Drug Name (Generic/Brand)	Strength/Dosage	Frequency	Reason for Medication

ALLERGIES

List your allergies including any medications that caused an allergic reaction.

List All Allergies	Describe Allergic Reaction

PAST MEDICAL HISTORY

Please provide a complete history including all illnesses, injuries, hospitalizations and operations

List All Surgeries	Date	Hospital	Treatment	Physician	Response to Treatment

MEDICAL PROBLEMS

Please list any past or current medical problems.

Date of Last *Colonoscopy* and/or *EGD*?	**Date of Last *Labs* done and *which physician*?**

FAMILY HISTORY

Please list all Blood Relatives with their current health status and any illnesses they have had or have.

List Blood Relatives	Current Health	Age, *If Living*	Age, *At Death*	Cause of Death	Illnesses
Father					
Mother					
Brother(s)					
Sister (s)					

SOCIAL HISTORY

Please check all that apply.

Mental Stress: Light Moderate Heavy Hours Per Day: _____ Smoking: Never Current Previous

Physical Work: Light Moderate Heavy Hours Per Day: _____ Caffeine: None Cups per Day_____

REVIEW OF SYMPTOMS

Check only the ones you have NOW or have had RECENTLY. Check NONE when applicable

GENERAL SYMPTOMS
- ❑ Chills
- ❑ Fever
- ❑ Night Sweats
- ❑ Feeling tired or poorly (malaise)
- ❑ Feelings of weakness

SKIN SYMPTOMS
- ❑ Skin lesions
- ❑ Rashes
- ❑ Dry Skin
- ❑ Other Skin related symptoms

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HEAD SYMPTOMS
- ❑ Headache
- ❑ Facial Pain
- ❑ Sinus Pain
- ❑ Other Head related symptoms _____

NECK SYMPTOMS
- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Lump or swelling in the neck
- ❑ Enlargement under Adam's apple
- ❑ Muscle aches in the neck or shoulder
- ❑ Other Neck related symptoms

BREASTS SYMPTOMS
- ❑ Breast Pain
- ❑ Nipple Discharge
- ❑ Breast lump
- ❑ Other Breast related symptoms

OTOLARYNGEAL SYMPTOMS (ENT)
- ❑ Hearing Loss
- ❑ Ringing in the Ears
- ❑ Discharge from Ears
- ❑ Ear Ache
- ❑ Itching of the Ears
- ❑ Dizziness
- ❑ Lightheadedness
- ❑ Sneezing
- ❑ Nasal Drip or Drainage
- ❑ Nasal Passage Blockage
- ❑ Nasal Discharge
- ❑ Mouth Dryness
- ❑ Mouth Sores
- ❑ Bleeding Gums
- ❑ Tooth Pain
- ❑ Bad Breath
- ❑ Peculiar Tastes, unrelated to food
- ❑ Sense of Taste Decreased
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Throat Pain
- ❑ Choking
- ❑ Other Otolaryngeal related symptoms

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EYES SYMPTOMS
- ❑ Blurry Vision
- ❑ Red Eyes
- ❑ Eye Pain Burning
- ❑ Swelling around Eyes
- ❑ Eye Pain
- ❑ Dry Eyes
- ❑ Watering discharge from eyes
- ❑ Other Eye related symptoms

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PULMONARY SYMPTOMS
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Coughing up Blood
- ❑ Wheezing
- ❑ Coughing up Phlegm
- ❑ Feeling Congested in the Chest
- ❑ Other Pulmonary related symptoms

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CARDIOVASCULAR SYMPTOMS
- ❑ Chest Pain and Discomfort
- ❑ Fast Heart Rate
- ❑ Palpitations
- ❑ Cold Hands and Feet
- ❑ Hands and Feet are Blue
- ❑ Regional soft tissue swelling both upper extremities
- ❑ Regional soft tissue swelling both lower extremities
- ❑ Pain in legs/Blue extremities
- ❑ Other Cardiovascular related symptoms

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BLOOD SYMPTOMS
- ❑ Easy Bleeding
- ❑ Swollen Glands in Neck
- ❑ Swollen Glands in Neck/Painful
- ❑ Easy Bruising Tendency
- ❑ Prolonged Bleeding
- ❑ Taking Blood Thinners
- ❑ Taking Aspirin
- ❑ Recent change in dosage of Anticoagulant Medications
- ❑ Other Blood related symptoms

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GASTROINTESTINAL SYMPTOMS
- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Bloating
- ❑ Belching
- ❑ Heartburn
- ❑ Change in Bowel Habits
- ❑ Increase BM Frequency
- ❑ Decrease BM Frequency
- ❑ Constipation
- ❑ Diarrhea
- ❑ Rectal Pain
- ❑ Flatus (Gas)
- ❑ Change in Appetite
- ❑ Black or Bloody Stools
- ❑ Difficulty Swallowing
- ❑ Other Gastrointestinal related symptoms

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GENITOURINARY SYMPTOMS
- ❑ Feelings of Urinary Urgency
- ❑ Urinary Incontinence w/o Sensory Awareness
- ❑ Pain in Flank
- ❑ Increased Urinary Frequency
- ❑ Burning Sensation
- ❑ Unable to Restrain Urination at Night While Sleeping
- ❑ Hematuria (Blood in Urine)
- ❑ Painful urination (Dysuria)
- ❑ Genital Lesion
- ❑ Abnormal Urethral Discharge
- ❑ Other Genitourinary related symptoms

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MUSCULOSKELETAL SYMPTOMS
- ❑ Joint Pain, localized
- ❑ Joint Stiffness, localized
- ❑ Muscle Aches
- ❑ Joint Swelling, localized
- ❑ Muscle Cramps
- ❑ Involuntary Movements, Muscle Twitches, (Tics)
- ❑ Back Pain
- ❑ Other Musculoskeletal related symptoms

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NEUROLOGICAL SYMPTOMS
- ❑ Vertigo
- ❑ Numbness (Hypesthesia)
- ❑ Weak Hand Grip
- ❑ Fainting (Syncope)
- ❑ Motor Disturbances
- ❑ Sensory Disturbances
- ❑ Memory Lapses and Loss
- ❑ Decreased Concentrating Ability
- ❑ Confused and Disoriented
- ❑ Shuffling Walking
- ❑ Convulsions
- ❑ Other Neurological related symptoms

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PSYCHOLOGICAL SYMPTOMS
- ❑ Sleep Disturbances
- ❑ Anxiety
- ❑ Depression
- ❑ Highly Irritable
- ❑ Thinking About Suicide
- ❑ Hallucinations
- ❑ Anxiety Attacks
- ❑ Libido Has Changed
- ❑ Other Psychological related symptoms_____

ENDOCRINE SYMPTOMS
- ❑ Excessive Sweating
- ❑ Excessive Thirst (Polydypsia)
- ❑ Recent Weight Loss (_____ lbs)
- ❑ Recent Weight Gain (_____ lbs)
- ❑ Temperature Intolerance to Heat (consistent)
- ❑ Temperature Intolerance Alternately too Hot and too Cold
- ❑ Other Endocrine related symptoms

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