MEDICAL HISTORY

NAME: _____ AGE: _____ SEX: M F
MARITAL STATUS: _____ OCCUPATION: _____

LIST OF MEDICATIONS AND DOSAGES: NONE: □
1. _____ 2. _____ 3._____ 4._____
5. _____ 6. _____ 7._____ 8._____

DRUG ALLERGIES: NONE: □ Drug(s): _____

RECENT CHANGES IN BOWEL HABITS	**IF** YOU HAVE ABDOMINAL PAIN
Yes No Diarrhea	Is it: constant daily weekly occasional rare
Yes No Constipation	Is it: severe moderate mild
Yes No Alternating diarrhea & constipation	Is it: sharp dull burning stabbing squeezing aching
Yes No Mucus in the stool?	constant throbbing other_____
Yes No Blood in the stool?	How long does it last? _____
Yes No Black stools?	What makes it better? _____
Yes No Narrow or ribbon-like stools?	What makes it worse? _____
Yes No Regularly use laxatives or enemas?	Does it radiate? Yes No If so, where to?_____
	Does it awaken you at night? Yes No

CHECK (If applicable)
[] Nausea [] Vomiting [] Heartburn [] Indigestion [] Difficulty Swallowing [] Loss of appetite
[] Fevers [] Weight loss [] Tattoos/Piercings, when_____ [] Blood transfusions, when_____

Yes No Have you ever had an upper endoscopy (EGD)? If so, when? _____
Yes No Have you ever had a colonoscopy? If so, when? _____
Yes No Have you ever had a pneumonia vaccine? If so, when? _____
Yes No Have you had a flu shot this year? If so, when? _____
Yes No Have you ever donated blood? If so, when? _____
Yes No Have you had a mammogram? If so, when? _____
Yes No Have you ever been screened for Hepatitis C? If so, when?_____

LIST <u>YOUR</u> MEDICAL CONDITIONS OR SURGERIES YOU HAVE HAD:
1._____2._____3._____4._____
5._____6._____7._____8._____

<u>FAMILY MEDICAL HISTORY: Do you or any of your blood relatives have or had</u>:
<u>GIVE RELATIONSHIP</u> F=Father; M=Mother; B=Brother; S=Sister; Self

Spastic colon	_____	Hepatitis	_____	Heart Valve Replacement	_____
Ulcerative colitis	_____	Stomach Ulcers	_____	Kidney disease	_____
Crohn's disease	_____	High Blood Pressure	_____	Diabetes	_____
Colon Polyps	_____	Stroke	_____	Asthma	_____
Colon Cancer	_____	Heart Attack	_____	Endocarditis	_____
Other cancers (what type) _____				Glaucoma	_____

PERSONAL HABITS:
Yes No Do you smoke or have you ever? How many packs/day _____ How many years? _____
Yes No Do you drink alcohol; if so (beer, wine, liquor)? How many on an average? _____
Yes No Do you drink coffee? How many cups per day? _____

<u>DESCRIBE</u> any problems you have with your:
Head: _____ Lungs: _____
Eyes: _____ Kidneys/Bladder: _____
Ears: _____ Joints/Muscles: _____
Mouth: _____ Nerves: _____
Heart: _____ Psychiatric: _____

Describe the problem that brings you here today: _____
_____