MedicalCenter Clinic
HEALTHCARE CENTERED AROUND YOU

## Gastroenterology History Form

**NAME:** ________________________________________ **DATE:** ________________________
**DATE OF BIRTH:** __________________________ **REFERRING PHYSICIAN:** _____________

Reason for today's visit:_____________________________________________________________

Past or present medical illness:______________________________________________________

Past surgeries or hospitalizations:___________________________________________________

Past GI evaluation/studies (please specify when): Gastroscopy/EGD______________________,
Colonoscopy_______________________, Flexible Sigmoidoscopy______________________,
CT Scan______________________, Other__________________________________________

**Family History (major health problems):**
Father:_______________________________________________________________________
Mother:______________________________________________________________________
Sister:_______________________________________________________________________
Brother:______________________________________________________________________
Children:_____________________________________________________________________

**Personal History:**
Medications:__________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Allergies:_____________________________________________________________________
_____________________________________________________________________________
Do you smoke? (how many packs per day?):________________________________________
Do you drink alchol? (how much per day/week?):___________________________________

Please check yes or no and indicate the length of time symptoms were present:

| SYMPTOMS | | | |
|---|---|---|---|
| Heartburn | ☐Yes | ☐No | Time Present_____________________ |
| Indigestion | ☐Yes | ☐No | Time Present_____________________ |
| Difficulty swallowing | ☐Yes | ☐No | Time Present_____________________ |
| Pain in swallowing | ☐Yes | ☐No | Time Present_____________________ |
| Nausea or vomiting | ☐Yes | ☐No | Time Present_____________________ |
| Vomiting blood | ☐Yes | ☐No | Time Present_____________________ |
| Abdominal pain | ☐Yes | ☐No | Time Present_____________________ |
| Bloating | ☐Yes | ☐No | Time Present_____________________ |
| Diarrhea, constipation or change | ☐Yes | ☐No | Time Present_____________________ |
| Passing blood or black bowel movement | ☐Yes | ☐No | Time Present_____________________ |
| Loss of appetite | ☐Yes | ☐No | Time Present_____________________ |
| Weight loss or gain and how much | ☐Yes | ☐No | Time Present_____________________ |
| Liver or gallbladder trouble | ☐Yes | ☐No | Time Present_____________________ |
| History or jaundice or Hepatitis | ☐Yes | ☐No | Time Present_____________________ |

## SYSTEMS REVIEW

As you review the following list, please check any of those problems which apply to you.

General: ☐fever ☐chills ☐headache ☐night sweats

Urinary: ☐pain on urination ☐blood in the urine

ENT: ☐yellow eyes ☐dry mouth

Muscles and joints: ☐frequent swelling ☐frequent joint aches

Allergic and Immunologic: ☐Itchy skin/hives ☐runny nose

Blood and Lymph: ☐ night sweats ☐easy bruising ☐easy bleeding

Lungs: ☐shortness of breath ☐frequent cough ☐wheezing ☐difficulty breathing

Neurologic: ☐weakness ☐vision loss ☐loss of sensation

Cardiovascular: ☐chest pain ☐cramps or pain in legs after walking some distance

Psychiatric: ☐depression ☐mania