

MEDICAL HISTORY

NAME _____ AGE _____ DATE _____

What gastrointestinal problems are you currently having? _____

Are you experiencing?

- Indigestion or ulcer pain: _____
- Abdominal pain: _____
- Nausea, vomiting: _____
- Heartburn: _____
- Difficulty swallowing: _____
- Change in bowel habits, constipation or diarrhea: _____
- Blood in the stool: _____
- Change in stool caliber: _____
- Rectal pain or discharge: _____
- Hemorrhoids: _____
- Gas, belching or bloating: _____
- Jaundice: _____
- Food or milk product intolerance: _____

Have you ever had?

- An Ulcer: _____
- Gallstones: _____
- Liver disease or hepatitis: _____
- Blood transfusions: _____
- Pancreatitis: _____
- Ulcerative colitis or Crohns disease: _____
- Colon polyps: _____
- Rectal problems: _____

Have you traveled in the past two years? _____ Where? _____

Have you had any antibiotics in the past year: _____?

Have you had any recent weight loss? _____

- Weight now: _____
- Weight one month ago: _____
- Weight six months ago: _____
- If yes, any change in appetite: _____

Please list any past medical problems for which you have been under treatment.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list any medication allergies.

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Please list any prior hospitalizations or surgeries.

	<u>Year</u>	<u>Problem</u>	<u>Operations</u>	<u>Hospital</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Please list all medications or pills that you take. List everything even if you only take it occasionally.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

What medications are you allergic to? _____

Do you have any other allergies? _____

Do you have any eye trouble? _____ Do you have Glaucoma? _____

Do you have any mouth or throat trouble? _____

Do you have any trouble with your heart, lungs, or blood vessels? _____

Heart Murmur: _____

Rapid or irregular heartbeat: _____

Shortness of breath or trouble breathing: _____

Swelling of ankles or feet: _____

Persistent cough, or coughed up blood: _____

Pain or pressure in chest: _____

Lung disease: _____

Do you have any skin problems? _____

Do you have any fevers or chills? _____

Do you have any trouble with urinary system? _____

Pain, burning, or infection: _____

Blood (red or brown) in urine: _____

Difficulty passing urine: _____

Difficulty holding urine: _____

Do you have any trouble with bones, joints? _____ Bursitis _____ Gout _____

Arthritis _____ Backache _____ Stiff Neck _____

Do you have any neurological or muscular trouble? _____

Dizziness, fainting, loss of balance: _____

Tremor, paralysis, loss of strength: _____

Headaches: _____

Psychiatric problems: _____

Is there a family history of? _____

Colon cancer or polyps: _____

Stomach cancer: _____

Other cancers: _____

Gallstones: _____

Ulcer disease: _____

Ulcerative colitis or Crohn's disease: _____

Other gastrointestinal disorders: _____

Do you have children? _____ How many? _____ Do they have any medical problems? _____

Do you smoke? _____ If yes, How much? _____ How long? _____

Have you ever smoked? _____ Year quit? _____

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____