Metropolitan Gastroenterology Assoc.

MEDICAL & FAMILY HISTORY FORM

Name: _____ **Today's Date:** _____

Date Of Birth: _____ **Height:** _____ **Weight:** _____

Referring Physician: _____ **Reason For Visit** _____

ALLERGIES

❑ None ❑ Demerol ❑ IV Contrast or iodine ❑ Penicillin ❑ Sulfa ❑ Codeine
❑ Aspirin ❑ Eggs ❑ Latex ❑ Propofol/Diprivan ❑ Versed

❑ Other: _____

PAST MEDICAL ILLNESSES

-- General --

❑ None	❑ Cardiac Arrhythmia	❑ Thyroid Disease	❑ Depression
❑ Anemia	❑ Stroke	❑ Convulsions/Seizures	❑ Arthritis
❑ Blood Clotting Problems	❑ Emphysema	❑ Kidney Disease	❑ Cataracts
❑ Sleep Apnea	❑ Pneumonia	❑ Back Problems	❑ Glaucoma
❑ High Blood Pressure	❑ Asthma	❑ Blood Transfusion(s)	❑ Gout
❑ Heart Attack	❑ Diabetes	❑ Anxiety disorder	❑ Other _____

-- Cancer --

❑ None ❑ Breast ❑ Colon ❑ Esophageal
❑ Liver ❑ Lung ❑ Prostate ❑ Other: _____

-- Gastrointestinal --

❑ None	❑ Crohn's Disease	❑ Gall Stones	❑ Hepatitis B
❑ Celiac Sprue	❑ Diverticulitis	❑ Cirrhosis of Liver	❑ Hepatitis C
❑ Acid Reflux/Heart Burn	❑ Diverticulosis	❑ Other Liver Disease	❑ Other Hepatitis
❑ Peptic Ulcer Disease	❑ Colon Polyps	❑ Hemorrhoids	❑ Pancreatitis
❑ Ulcerative Colitis	❑ Irritable Bowel Syndrome	❑ Hepatitis A	❑ Other: _____

PREVIOUS SURGERIES ▪ PROCEDURES ▪ HOSPITALIZATIONS

❑ None	❑ Cardiac Bypass	❑ Gastric Bypass/Surgery	❑ Sigmoidoscopy
❑ Tonsils	❑ Heart Valve Replacement	❑ Gall Bladder Removal	❑ Colonoscopy
❑ Appendix Removal	❑ C-section	❑ Colon Surgery	❑ Capsule Endoscopy
❑ Prostate	❑ Hysterectomy	❑ Colostomy	❑ ERCP
❑ Joint Surgery	❑ Ovary Removal	❑ Tubal Ligation	❑ Other: _____
❑ Implanted Defibrillator (ICD)	❑ Breast	❑ EGD	

SOCIAL HISTORY

-- Marital Status --

❑ Single ❑ Married ❑ Widowed ❑ Divorced

-- Recreational Drugs --

❑ I have never used recreational drugs. ❑ I have used recreational drugs in the past. ❑ I am currently using recreational drugs ❑ I have been treated for drug abuse.

-- Alcohol Consumption --

❑ Never ❑ 1-5 drinks per week ❑ 6-10 drinks per week ❑ More than 10 drinks per week ❑ Prior history of more than 10 drinks per week

-- Tobacco Use --

❑ Have never smoked
❑ Currently Smoke Packs per day: _____ Number of years: _____
❑ Have quit smoking Packs per day: _____ Number of years: _____

-- Occupation --

❑ Retired ❑ Active *(please list)*: _____

MEDICATIONS

Name of Medication	Strength	How Often	Name of Medication	Strength	How Often

Name: _____ **Today's Date:** _____

REVIEW OF SYSTEMS

Please indicate if your are experiencing, or have experienced **in the last six (6) months**:

-- Gastrointestinal --

❑ None	❑ Blood in Stool	❑ Heartburn	❑ Milk Intolerance
❑ Abdominal pain	❑ Change in Bowel Habits	❑ Incontinence to Stool	❑ Trouble Swallowing
❑ Belching	❑ Constipation	❑ Nausea & Vomiting	❑ Painful Swallowing
❑ Black Stool	❑ Diarrhea	❑ Jaundice	❑ Pain with bowel movement
❑ Bloating	❑ Gas	❑ Loss of Appetite	❑ Other_____

-- Genitourinary --

❑ None ❑ Blood in Urine ❑ Urinary Incontinence ❑ Frequent Urinary Infections ❑ Other: _____

-- Skin --

❑ None ❑ Itching ❑ Rash ❑ Other: _____

-- Cardiovascular --

❑ None ❑ Angina/Chest Pressure with Activity ❑ Ankle Swelling ❑Irregular Heart Beat
❑ Passing out ❑ Palpitation ❑ Other: _____

-- Endocrine --

❑ None ❑ Cold Intolerance ❑ Excessive Thirst ❑ Other: _____

-- Neurological --

❑ None ❑ Headaches ❑ Seizures ❑ Stroke or Paralysis ❑ Other_____

-- Constitutional --

❑ None ❑ Weight Loss ❑ Fever ❑ Weight Gain

-- Psychiatric --

❑ None ❑ Anxiety ❑ Depression ❑ Memory Loss

-- Eyes --

❑ None ❑ Change in Vision ❑ Dry Eyes ❑ Eye Pain

-- Hematologic --

❑ None ❑ Enlarged Glands ❑ Prolonged Bleeding ❑ Use of Plavix, Coumadin or other blood thinners

-- Ears, Nose and Throat --

❑ None ❑ Bleeding Gums ❑ Hoarseness ❑ Mouth Sores ❑ Nose Bleeds

-- Musculoskeletal --

❑ None ❑ Back Pain ❑ Muscle Pain ❑ Joint Pain

-- Respiratory --

❑ None ❑ Chronic Cough ❑ Shortness of Breath ❑ Other_____

-- Immunologic --

❑ None ❑ Ear Infections ❑ Flu ❑ Pneumonia ❑ Other_____

FAMILY HISTORY

	Father	Mother	Child(ren)	Brother(s)	Sister(s)	GrandParents
Breast Cancer	❑	❑	❑	❑	❑	❑
Colitis	❑	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑	❑
age at diagnosis	_____	_____	_____	_____	_____	_____
Colon Polyps	❑	❑	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	❑	❑
Esophageal Cancer	❑	❑	❑	❑	❑	❑
Gastric Cancer	❑	❑	❑	❑	❑	❑
Heart Problems	❑	❑	❑	❑	❑	❑
Liver Disease	❑	❑	❑	❑	❑	❑
Pancreatic Cancer	❑	❑	❑	❑	❑	❑
Skin Cancer	❑	❑	❑	❑	❑	❑
Other:	_____	_____	_____	_____	_____	_____