PATIENT HEALTH HISTORY FORM **GASTRO CONSULTANTS OF ATLANTA, P.C.**

To our patients: **Welcome to our practice. Please take your time to complete this form.**
If you have any questions, please ask for assistance. Thank you.

____
LAST NAME FIRST NAME MIDDLE INITIAL/NAME

Who referred you to our office? ______________________ **TODAY'S DATE:** ______________

Please list any other physicians involved in your care: ______________________

DATE OF BIRTH: ______________ **PLACE OF BIRTH:** ______________ **OCCUPATION** ______________

MARITAL STATUS: ___Single ___Married ___Separated ___Widow/Widower ___Divorced ___Partnered

REASON FOR VISIT: Please describe the problem which prompted your visit? ______________________

Please list any lab tests, procedures or X-ray/radiology studies performed (e.g. by another physician or ER visit), that may relate to your current problem: ______________________

Pharmacy name:______________________ **Phone**:______________________

MEDICATIONS: Please list all prescribed **OR over-the-counter** medications/supplements (including vitamins and herbal compounds) prescribed or taken recently. **Please include the dose and frequency for each item listed.**

DO YOU TAKE: **Aspirin? [ ] YES [ ] NO** **Anti-inflammatory pain medications (e.g. *Motrin, Advil*, etc.)? [ ] YES [ ] NO**

ALLERGIES TO MEDICATIONS:

____

OTHER ALLERGIES: ______________________
Any problems with iodine or intravenous contrast (dye)? [ ] YES [ ] NO Novocaine? [ ] YES [ ] NO
Have you ever experienced any problems with anesthesia? [ ] YES [ ] NO Explanation: ______________

SURGICAL HISTORY: Please list **ANY** operations/surgical procedures performed in the past?

YEAR	TYPE OF SURGERY	SURGEON/HOSPITAL (If known)

HOSPITALIZATIONS: Please list any medical illnesses that required hospitalization (other than for surgery or childbirth)

DATE OF LAST COLONOSCOPY: ______________ **or [ ]** Never **REASON FOR EXAM:** ______________

PHYSICIAN WHO PERFORMED EXAM: ______________ **FINDINGS:** ______________

Name:_________________________ **Date of Birth: ____________________**

Other major medical illnesses or problems not included above:

____

____

____

____

____

FAMILY HISTORY: Any member of your **family** (including parents, grandparents, siblings and children) ever had the following?

Illnesses affecting **OTHER** family members	Relationship to you?	How old when diagnosed?
Colon polyps or cancer of the colon	________	____
Breast cancer	________	____
Cancer – other type (describe part of body affected)	________	____
Ulcer disease	________	____
Liver diseases (cirrhosis, hepatitis, etc.)	________	____
Inflammatory bowel disease (Crohn's or ulcerative colitis)	________	____
Gallbladder disease/stones or prior gallbladder surgery	________	____
Hypertension/high blood pressure	________	____
Heart disease	________	____
Diabetes	________	____
Mental / psychiatric disorder(anxiety, depression, suicide, etc.)	________	____
Drug or alcohol addiction	________	____
Bleeding tendency	________	____
Obesity	________	____

Any other important illness(es) ____

YOUR PERSONAL HABITS:

Smoking: Do you **now**, **or have you ever** been a smoker? .... **[ ] YES** **[ ] NO, I NEVER SMOKED**

Average use (estimate): _____ packs each day for approximately _____ years

If you are a **former** smoker, when did you stop? _______________.

Alcohol: Do you drink any alcoholic beverages? .... **[ ] YES** **[ ] NO**

Quantity? (please **estimate** the **average** amount) : _____ mixed drinks _____ glasses of wine _____ beer

How often do you drink this amount? (*circle* one answer) **per** DAY / WEEK / MONTH / YEAR

Have you ever been told or thought that you were an alcoholic? .... **[ ] YES** **[ ] NO**

Drugs: Have you **ever** (EVEN ONCE) used a needle/syringe to inject street drugs? .... **[ ] YES** **[ ] NO**

Do you now or have you ever used other illicit, illegal or "recreational" drugs? .... **[ ] YES** **[ ] NO**

Please explain: ____

CLINICAL NOTES [FOR OFFICE USE ONLY]:

Name:______________________________ **Date of Birth:** ___________________________

REVIEW OF SYSTEMS: These are some general health questions– please indicate with an **X** or [***check mark***] if **YOU** have currently or in the past experienced (*to a significant degree*) the following problems. Please provide details as appropriate.

CONSTITUTIONAL:

_____ Significant change in appetite? ....

_____ Have you had any **recent** weight change?............................

_______ lbs [ ] Loss [ ] Gain Since when? _______

_____ Recent fever? ....

_____ Night sweats? ....

SKIN DISORDERS:

_____ Eczema? ....

_____ Hives? ....

_____ Rash requiring treatment? ....

_____ Unexplained itching? ....

_____ Skin cancer? ....

HEAD-EYES-EARS-MOUTH-NOSE:

_____ Any serious head injury? ....

_____ Difficulty seeing? ....

_____ Eyeglasses or contact lenses?...

_____ Cataracts or glaucoma..

_____ Any hearing loss? ....

_____ Loss of smell? ....

_____ Mouth sores? ....

CARDIOVASCULAR:

_____ High blood pressure? ....

_____ A racing heart/palpitations? ....

_____ Chest pains or tightness with exertion (walking/ climbing)? ......

_____ Waking up at night short of breath? ....

_____ Swollen feet or ankles? ....

_____ Leg cramps or leg discomfort with walking? ....

_____ Heart murmur? ....

_____ Artificial heart valve? ....

_____ Any infection of a heart valve? ....

_____ Heart attack? ....

_____ Pacemaker? ....

RESPIRATORY:

_____ Wheezing or asthma? ....

_____ Coughing up a lot of phlegm (sputum).....................................

_____ Coughing up blood? ....

_____ Chronic bronchitis? ....

_____ Emphysema? ....

_____ Tuberculosis? ....

_____ Awakened at night with coughing or choking?.........................

GASTROINTESTINAL:

_____ Hepatitis (liver infection) Type A, B or C or jaundice? ....

_____ Cirrhosis (scarring of the liver)? ....

_____ Other liver problem or abnormal liver tests? ....

_____ Disease of the pancreas (including pancreatitis)? ....

_____ Gallbladder problems/stones? ....

_____ Problems swallowing food? ....

_____ Heartburn or indigestion? ....

_____ Bloating? ....

_____ Abdominal pain? ....

_____ Recent changes in bowel movements? ....

_____ Frequent use of laxatives or enemas?......................................

_____ Black or tarry bowel movements? ....

_____ Blood in your stools/bowel movements? ....

_____ Colon polyps? ....

_____ Stomach/duodenal ulcers? ....

_____ Vomiting blood? ....

_____ Milk / lactose intolerance? ....

PSYCHIATRIC:

_____Hospitalized for nervous breakdown? ....

_____Tension/Anxiety/Depressive Disorder? ....

_____ Bipolar Disorder? ....

_____ Schizophrenia? ....

_____ Ever attempted suicide or serious thoughts about suicide? …

ENDOCRINE:

_____ Thyroid disease? ....

_____ Diabetes requiring insulin? ....

_____ Diabetes requiring pills/diet? ....

_____ Any unusual sweating? ....

_____ Calcium or bone problems? ....

HEMATOPOIETIC/LYMPHATIC:

_____ Anemia or history of anemia?

_____ Blood transfusions **EVER** in the past..................................

When? ______________________

_____ Tendency to bleed easily when cut? ....

_____ Blood clotting disorder? ....

_____ Are you known to be HIV (AIDS antibody positive)? ....

_____ Swelling of any lymph glands? ....

Name: _________________________ **Date of Birth:**_____________

MUSCULOSKELETAL:

_____ Back pain (as a frequent or serious/continuing problem)? ....

_____ Muscle weakness or muscle disease? ....

_____ Arthritis? ....

_____ Stiff or painful muscles or joints? ....

_____ Joints ever swollen? ....

When was your last bone density test (for osteoporosis)? __________

Was it normal? YES NO ________________________________

GENITOURINARY:

_____ Kidney disease? ....

_____ Kidney stones or past history of kidney stones? ....

_____ Painful or difficult urination? ....

_____ Blood in your urine? ....

(***FOR MEN ONLY):***

_____ Weak or very slow urine stream? ....

_____ Prostate trouble? ....

_____ Discharge from your penis? ....

_____ Swelling or lumps in your testicles? ....

_____ Painful testicles? ....

NEUROLOGICAL:

_____ Epilepsy or seizures?...

_____ Stroke? ....

_____ Frequent or severe headaches? ....

_____ Dizziness or blackout spells?...

GYNECOLOGIC (*FOR WOMEN ONLY*):

When was your last menstrual period?________ Was it normal? YES NO

When was your last PAP smear?_____________ Was it normal? YES NO

When was your last mammogram?__________ Was it normal? YES NO

Pregnancies : Total # pregnancies _____

____Births; ____ Miscarriages; ___ Abortions

_____ Excessive bleeding with your periods? ....

_____ Bleeding between your periods? ....

_____ Lumps in your breasts? ....

_____ Cancer in the female organs? ....

_____ **Do you think you may be pregnant?**

Immunizations:

______ Influenza .... year__________

______ Pneumonia vaccine ....year__________

______ Hepatitis A....................................year __________

______ Hepatitis B....................................year __________

______ Shingles....................................... year __________

______ Tetanus .... year __________

If there are any other medical problems or questions you would like to address with the physician or staff, please use the space below to record your information:

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This information will be kept in your chart, and may be easily updated in the future.
We welcome any comments or suggestions that might improve the quality of your visit.
Thank you for your cooperation.

Reviewed by ____________________________ **DATE** ____________