

Date: _____

Patient Name – First _____ Last _____

Referring Physician: _____

SOCIAL HISTORY

AGE: _____

MARITAL STATUS: _____

OCCUPATION: _____

OF CHILDREN: _____

RACE: _____

Family History

FAMILY MEMBER	LIVING	DECEASED	AGE @ DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHER/SISTER				
HUSBAND/WIFE				
SON/DAUGHTER				

GASTROINTESTINAL SYMPTOMS

(Please circle the appropriate response)

General

1. Trouble swallowing? Yes No
 If yes, how long? _____

2. Is swallowing painful? Yes No

3. Do you have difficulty swallowing? Solids Pills Liquids

4. Do you have nausea? Yes No
 If yes, how often? _____

5. Do you have heartburn? Yes No
 If yes, how often? _____

6. Do you smoke? Yes No
 If yes, how long? _____
 Packs per day: _____

7. Do you drink alcohol? Yes No
 If yes, how many drinks per day: _____

OVER

- | | | | |
|---|----------------------------|-------------------------|-------------------------------------|
| 8. Has your weight changed? Gain/Loss
If yes, How much? _____
Over what period of time? _____ | Yes | No | |
| 9. Do you drink coffee?
Cups per day: _____ | Yes | No | |
| 10. Do you drink coke/soda?
How many per day? _____ | Yes | No | |
| 11. Do you take arthritis medication?
What kind? _____
How many per day? _____ | Yes | No | |
| 12. Do you take Aspirin?
How many per day? _____ | Yes | No | |
| 13. Is there any family history of bowel disease?
Family member? _____
Nature of disease? _____ | Yes | No | |
| 14. Is there any history of bowel cancer?
Family member? _____
Nature of disease? _____ | Yes | No | |
| 15. Do you have a history of ulcers?
When were you diagnosed? _____ | Yes | No | |
| 16. Do you have frequent indigestion? | Yes | No | |
| 17. Do you have abdominal pain?
Location of pain? _____ | Yes | No | |
| 18. Is the pain? | Colicky | Constant | |
| 19. Is the abdominal pain better or worse with:
Eating
Passing stool
Belching/passing gas | Better
Better
Better | Worse
Worse
Worse | No Change
No Change
No Change |
| 20. Have you ever had liver disease?
If yes, what disease? | Yes
Jaundice | No
Hepatitis | |
| 21. Have you ever had gallbladder disease? | Yes | No | |
| 22. Is there a family history of liver disease?
If yes, which family member? _____ | Yes | No | |
| 23. Have you ever had pancreatitis? | Yes | No | |
| 24. Have you had a change in bowel habits? | Yes | No | |
| 25. Which occurs more? | Constipation | Diarrhea | Normal Stools |
| 26. How many stools per day? _____ | | | |

OVER

27. Please describe stools: (please circle one)	Watery	Loose	Hard	Pellet Like	Well Formed
28. Have stools become pencil like?		Yes			No
29. Is there blood in the stool? If yes, what color is the blood? _____		Yes			No
30. Do you have a history of hemorrhoids?		Yes			No
31. Do you have diarrhea?		Yes			No
Have you been on an antibiotic recently?		Yes			No
Have you drank out of any lakes/streams?		Yes			No
Have you had any foreign travel?		Yes			No
32. Additional information: _____					

MEDICAL HISTORY

1. Do you have a history of cancer? If yes, what organ? _____ Diagnosed when? _____ Treatment? _____ Other? _____	Yes				No
2. Do you have a history of heart disease? If yes, what type? _____ Comment _____	Yes				No
3. Do you have a history of lung disease? If yes, what type? _____ Comment _____	Yes				No
4. Do you have hypertension? (high blood pressure) If yes, your treatment is? _____ Comment _____	Yes				No
5. Do you have vascular disease? Comment _____	Yes				No
6. Do you have diabetes mellitus? If yes, year diagnosed? _____ Juvenile onset? Adult onset? Insulin dependent? Diet controlled? Controlled on oral medication?	Yes				No
Yes		Yes			No
Yes		Yes			No
Yes		Yes			No
Yes		Yes			No
Yes		Yes			No
7. Do you have a history of kidney disease? Comment _____	Yes				No
8. If male, do you have prostate problems? Comment _____	Yes				No
9. Do you have neurological problems? If yes, what type? _____	Yes				No

OVER

10. Do you have arthritis? Comment _____	Yes	No
11. Do you have thyroid problems? Comment _____	Yes	No
12. If female, reproductive system: Do you have problems with your breast(s)	Yes	No
Do you have problems with your uterus	Yes	No
Do you have problems with your ovary(ies)	Yes	No
Comment _____		
13. Other medical problems _____		

SURGICAL HISTORY

History of surgical procedures	Yes	No
Past surgeries: _____	Date _____	
_____	Date _____	
_____	Date _____	
_____	Date _____	
_____	Date _____	
Comments _____		

SYSTEM REVIEW

Please describe problems with the following; If no problems present, please write "NONE"

1. Head, Eyes, Ears, Nose and Throat: _____
2. Lungs: _____
3. Heart: _____
4. Kidneys, Bladder: _____
5. Muscles, Bones and Joints (arthritis, etc) _____
6. Neurological Conditions (stroke, etc) _____
7. Endocrine Conditions (thyroid, etc) _____
8. Psychiatric Conditions (depression, panic attacks, schizophrenia, etc) _____

I have utilized this medical information as part of the patient consultation:

Provider signature