Digestive MEDICINE ASSOCIATES, LLP

MEDICAL HISTORY FORM

Patient's Name: _____ Today's Date_____ Last Visit Date: _____

Date of Birth: _____ Age: _____ Sex: F / M Referring Physician: _____

Pharmacy Name / Address / Phone: _____

REASON FOR TODAYS VISIT: _____

PERSONAL MEDICAL HISTORY

Please check all that apply

- ☐ Anemia
- ☐ Barrett's Esophagus
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Diarrhea-Chronic
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Elevated Liver Enzymes
- ☐ Gallstones
- ☐ GI Bleed-Upper
- ☐ GI Bleed-Lower
- ☐ GED (Reflux)
- ☐ Valvular Heart Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Ulcerative Colitis
- ☐ Hx of Breast Cancer
- ☐ Hx of Colon Cancer
- ☐ Hx of Esophageal Cancer
- ☐ Hx of Cervical Cancer
- ☐ Hx of Gastric Cancer
- ☐ Hx of Prostate Cancer
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disorder
- ☐ Congestive Heart Failure
- ☐ COPD / Emphysema
- ☐ Coronary Artery Disease
- ☐ CVA / Stroke
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ DVT
- ☐ Peptic Ulcer Disease
- ☐ Endocarditis
- ☐ High Cholesterol
- ☐ Myocardial Infarction
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Neurologic Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Other: _____ _____
- ☐ None of the Above

SURGICAL HISTORY AND HOSPITALIZATIONS

- ☐ None
- ☐ Please list all surgeries / hospitalizations, dates and reasons:

__/__/__ _____

__/__/__ _____

FAMILY HISTORY

Check all that apply. Indicate family member(s) an age of diagnosis

Colon Cancer _____
Colon Polyps _____
Crohn's Disease _____
Diverticulitis _____
Diverticulosis _____
Gallbladder Disease _____
Stomach Cancer _____
Liver Disease _____
Pancreatitis _____
Ulcerative Colitis _____
Ulcers _____
Other _____

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SOCIAL HISTORY

Check all that apply

Tobacco ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker

☐ Never smoker

Alcohol Use ☐ No ☐ Yes (Type _____) (Drinks per day _____) (Drinks per week _____)
Caffeine ☐ No ☐ Yes (Drinks per day _____)
Drug Use ☐ None ☐ 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 substance abuse_____

CURRENT MEDICATIONS

Please list all your medications and dosages for each. Include over the counter medications and supplements

Medication Name	Dosage	Medication Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any drug allergies? _____ Any other allergies? _____

PROCEDURE HISTORY

When was your last procedure? What were the results?

☐ Colonoscopy __/__/__ Normal or _____
☐ Upper Endoscopy (EGD) __/__/__ Normal or _____
☐ Flexible Sigmoidoscopy __/__/__ Normal or _____
☐ I have never had any endoscopies

The Medical information provided is complete and true to my knowledge.

_____ _____
Patient Signature Date

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Height: _____ Weight: _____ BP _____ Pulse: _____

Allergies: _____ Sleep Apnea: ☐ Yes ☐ No

Reason for Procedure: ☐ Screening ☐ Family History of Colon Cancer ☐ Personal History of Polyps

Staff Signature _____ Date _____