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____
Patient Name:

_______________________________ DATE: ___________________________
Date of Birth:

Consult requested by Dr. ______________________ for ____

Race

___ White/Caucasian ___ Black or African American ___Asian ___Hispanic or Latino
___ American Indian or Alaska Native ___Native Hawaiian or Other Pacific Islander ___ Mixed ___ Other
___ Unknown ___ Patient declines to provide information

Ethnicity
___ Hispanic or Latino ___Not Hispanic or Latino ___Patient declines to provide information

Preferred Language
___ English ___Spanish ___Other __________________

Contact Preference
___ Home phone / voice mail ___ Work phone / voice mail ___Cell phone / voice mail

Allergies _______ No Known Drug Allergies Are you allergic to Latex? Yes / No

I am allergic to: ____

Current Medications

Medication	Dosage	Medication	Dosage
1.		10.	
2.		11.	
3.		12.	
4.		13.	
5.		14.	
6.		15.	
7.		16.	
8.		17.	
9.		18.	

Patient Name: ____________________________________

Diagnostic Studies / Tests

Tests:	Where / When
Blood Tests	
CAT Scan	
EKG	
Stool Occult Blood Test	
Ultrasound	
X-Rays	
Other	

Previous Procedures

	None		Upper Endoscopy When:		Colonoscopy When:		Gastric Bypass: When:		Removal of Gallbladder When:
	Appendectomy When:		Uterus/Tubes/Ovaries When:		Stomach/Bowel/Colon When:		Heart Bypass When:		Pace Maker When:
	Defibrillator When:		Cardiac Stents When:		When:		When:		When:

Other procedures / surgeries not listed above: ____

Past or Present Medical Conditions

Please check the box in front of conditions you currently experience or have had in the past:

	None		Anemia		Angina/Chest pain		Anxiety		Arthritis		Asthma
	Cholesterol Problems		Colitis		Colon Polyps		COPD		Crohn’s Disease		Depression
	Diabetes		Disease of Pancreas		Emphysema		Esophagitis		Gallbladder Disease		GERD
	Heart Attack		Heart Disease		Hemorrhoids		Hepatitis		High Blood Pressure		HIV/AIDS
	Irregular Heartbeat		Irritable Bowel Syndrome/IBS		Jaundice		Kidney Disease		Liver Disease		Rheumatic Fever
	Seizure Disorder		Sleep Apnea		Stroke		Thyroid Disease		TIA		Ulcers

Social History - Marital Status

	Single		Married		Divorced		Separated
	Widowed		Civil Union		Unknown		Other

Alcohol ___ None

Type ______________ Amount ______________ Frequency ______________

Type ______________ Amount ______________ Frequency ______________

Caffeine ___None

Type ______________ Amount ______________ Frequency ______________

Type ______________ Amount ______________ Frequency ______________

Tobacco

Smoking Status
___ Current every day smoker ___Current some day smoker ___ Former smoker ___Never smoker
___Smoker, current status unknown ___Unknown if ever smoked

Type ______________ Started ______________ Quit ______________ Quantity ______________ Frequency ______________

Drug Use ___None
___Used IV drugs in the past ___Used other drugs in the past ___Use recreational drugs now

Family Medical History ___No Knowledge of family history

Do you have a family history of:

Celiac Sprue Yes / No
Colon Polyps Yes / No
Liver Disease Yes / No
Colon Cancer Yes / No
Inflammatory Bowel Disease Yes / No
Ulcer problems Yes / No

Diagnosis **FAMILY HISTORY**	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather
Celiac Disease										
Colon Cancer										
Colon Polyps										
Inflammatory Bowel Disease										
Liver Disease										
Stomach problems / ulcers										
Gallbladder problems										
Pancreas problems										
Heart Disease										

Review of Systems Do **you** experience any of the following?

CARDIOVASCULAR
____ None
Y / N Chest pain
Y / N Palpitations
Y / N Shortness of breath
Y / N Swelling of ankles / feet

CONSTITUTIONAL
____ None
Y / N Fatigue
Y / N Fever
Y / N Weight gain
Y / N Weight loss
Y / N Problems with anesthesia or sedation

EARS/NOSE/THROAT/MOUTH
____ None
Y / N Hearing loss
Y / N Mouth sores
Y / N Ringing in ears

ENDOCRINE
____ None
Y / N Excessive thirst
Y / N Excessive urination
Y / N Cold intolerance
Y / N Heat intolerance

EYES
____ None
Y / N Blurred vision
Y / N Glaucoma

GASTROINTESTINAL
____ None
Y / N Abdominal pain
Y / N Belching
Y / N Black, tarry stools
Y / N Bloating
Y / N Blood in stool
Y / N Change in bowel habits
Y / N Constipation
Y / N Diarrhea
Y / N Difficulty swallowing
Y / N Heartburn
Y / N Nausea
Y / N Poor appetite
Y / N Rectal bleeding
Y / N Regurgitation
Y / N Stomach cramps
Y / N Vomiting

GENITOURINARY
____ None
Y / N Burning with urination
Y / N Blood in urine
Y / N Are you or could you possibly be pregnant?

HEMATOLOGIC/ LYMPHATIC
____ None
Y / N Anemia
Y / N Blood transfusion in the past
Y / N Easy bruising
Y / N Prolonged bleeding

SKIN
____ None
Y / N Itching
Y / N Rashes

MUSCULOSKELETAL
____ None
Y / N Back pain
Y / N Joint pain
Y / N Joint swelling
Y / N Muscle pain
Y / N Muscle weakness

NEUROLOGICAL
____ None
Y / N Frequent headaches
Y / N Numbness or tingling
Y / N Seizures
Y / N Stroke

PSYCHIATRIC
____ None
Y / N Anxiety
Y / N Depression
Y / N Memory loss or confusion

RESPIRATORY
____ None
Y / N Coughing
Y / N Spitting up blood
Y / N Wheezing

Pharmacy

Name: ______________________________ Phone Number: ______________________

If necessary, your medical information can be released to someone other than yourself. Please list names of authorized people:

Spouse: ______________________________ _____Yes _____ No

Parent: ______________________________ _____ Yes _____ No
Other Names: (Please list relationship such as daughter, son, boyfriend, girlfriend, fiancé, sister, etc.)

____

Patient Signature - All information contained on these patient history forms is true and correct to the best of my belief.

Signature: ______________________________ Date: ______________________