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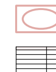
Direction of Feed

Patient Medical History

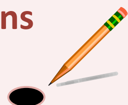
Please answer every question

STAFF: Responses in boxed bubbles and handwritten items must be entered MANUALLY.



Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Please complete this history form. This will allow us to serve your health needs.
The information contained herein is strictly confidential and will not be released unless you authorize us to do so.

PATIENT MEDICAL HISTORY

Mark all conditions that you have had. If you have had none in a category, mark NONE.

GASTROINTESTINAL CONDITIONS

- Celiac Disease or Sprue
- Gastrointestinal Bleeding
- Irritable Bowel Syndrome (IBS)
- Yellow Skin / Jaundice
- Helicobacter Pylori (H. pylori)
- Intestinal Infection
- Bowel Obstruction
- Acid Reflux / GERD
- Liver Failure / Cirrhosis
- Gallbladder Problems
- Anal Fissure
- Colon Polyps
- Diverticulitis
- Diverticulosis
- Crohn's Disease
- Hiatal Hernia
- Pancreatitis
- Hemorrhoids
- Hepatitis A
- Hepatitis B
- Hepatitis C

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- Stomach Ulcer / Duodenal Ulcer
- Esophageal Stricture / Narrowing
- Barrett's Esophagus
- Chronic Constipation
- Ulcerative Colitis
- Alcohol Abuse
- **Other**
- **NONE**

NON-GASTROINTESTINAL CONDITIONS

- Congestive Heart Failure
- Hardening of the Arteries
- Heart Disease / Heart Attack
- Treatment with Blood Thinner
- Abnormal Heartbeat / Palpitations
- Antibiotic Treatment within the Past 2 Months
- HIV Exposure
- Seizure Disorder
- Multiple Sclerosis (MS)
- Bleeding Disorder
- High Blood Pressure
- Emphysema / COPD
- Kidney Disease
- Diabetes
- Blood Clots
- HIV Positive
- Fibromyalgia
- Thyroid Disease
- Lupus
- Stroke
- Anemia
- Arthritis
- Asthma
- **NONE**

CANCER

- Esophageal
- Mouth / Throat
- Colon / Rectal
- Blood (e.g., Leukemia)
- Ovarian
- Stomach
- Prostate
- Pancreatic
- Skin
- Lungs
- Uterine
- Breast
- Liver
- **Other**
- **NONE**

FAMILY HISTORY

Fill in the oval if a relative has had one of the following.

- **Family History Unknown**
- **Adopted**
- **Other Family History Not Listed**
- **NONE**

- Mental Illness
- Prostate Cancer
- Stomach Cancer
- Bleeding Disorder
- Irritable Bowel Syndrome
- Cirrhosis
- Celiac Disease
- Breast Cancer
- Ovarian Cancer
- Crohn's Disease
- Ulcerative Colitis
- Cancer, Other
- Liver Failure
- Liver Cancer
- Heart Attack
- Hypertension
- Stroke
- Diabetes
- Sickle Cell
- Gallstones

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- Hemochromatosis
- Autoimmune Hepatitis
- Alcohol Abuse
- Uterine Cancer
- Blood Clots
- Pancreatitis
- Ulcer Disease
- Tuberculosis (TB)
- Hepatitis B
- Hepatitis C

Have any of your blood relatives had **Colorectal Cancer?**

	Yes	No	20's	30's	40's	50's	60's	70's	80+
			Age relative developed condition, if known						
Mother									
Father									
Sister									
Brother									
Daughter									
Son									
Other									

Have any of your blood relatives had **Colon Polyps?**

	Yes	No	20's	30's	40's	50's	60's	70's	80+
			Age relative developed condition, if known						
Mother									
Father									
Sister									
Brother									
Daughter									
Son									
Other									

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Direction of Feed

Patient Medical History

Please answer every question

STAFF: Responses in boxed bubbles and handwritten items must be entered MANUALLY.

CURRENTLY ACTIVE SYMPTOMS, TESTS & OTHER CONDITIONS

Mark all that apply. If you have no symptoms in a category, mark NONE.

Patient Name: ______________________

Category				
GENERAL	night sweats ◯ / tiredness ◯	fever ◯ / lack of appetite ◯	unintentional weight loss (over 10 lbs) ◯	NONE ◯
HEAD, EARS, EYES, NOSE & THROAT	wear glasses ◯ / wear contacts ◯	glaucoma ◯ / hoarseness ◯	headache ◯ / sleep apnea ◯ / decreased hearing ◯	NONE ◯
CARDIOVASCULAR	heart stent ◯ / chest pain ◯	swelling of hands or feet ◯ / elevated blood pressure ◯	leg cramps ◯ / fainting / blacking out ◯	NONE ◯
GENITOURINARY	blood in urine ◯	change in urinary stream ◯ / painful urination ◯	pelvic pain ◯ / urinary frequency ◯	NONE ◯
NEUROLOGICAL	dizziness ◯ / fainting ◯	loss of consciousness ◯ / weakness in extremities ◯	seizures ◯ / difficult speech ◯	NONE ◯
ENDOCRINE		cold intolerance ◯ / heat intolerance ◯	excessive thirst ◯ / excessive urination ◯	NONE ◯

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Category				
MUSCULOSKELETAL	backache ◯	joint stiffness ◯	physical disability ◯	NONE ◯
SKIN		itching ◯	rash ◯	NONE ◯
RESPIRATORY	chronic cough ◯	difficulty breathing ◯	wheezing ◯	NONE ◯
PSYCHIATRIC	suicidal thoughts ◯	depression ◯	anxiety ◯	NONE ◯
BLOOD			easy bruising ◯	NONE ◯
BREAST		breast mass ◯	breast pain ◯	NONE ◯

GASTROINTESTINAL

			constipation ◯	heartburn ◯
nausea ◯	food / milk intolerance ◯	painful swallowing ◯	vomiting blood ◯	belching ◯
diarrhea ◯	get full quickly at meals ◯	difficulty swallowing ◯	abdominal pain ◯	black stool ◯
bloating ◯	change in bowel habits ◯	stool incontinence ◯	blood in stool ◯	laxative use ◯
vomiting ◯	painful bowel movement ◯	abdominal swelling ◯	gas / flatulence ◯	NONE ◯

Has your stool tested positive for blood in the past 6 months? no ◯ yes ◯

Have you had any of these procedures?

NO	YES	Procedure	Date	Findings
◯	◯	**Colonoscopy**	Date: ______	Findings: ______
◯	◯	**Flexible Sigmoidoscopy**	Date: ______	Findings: ______
◯	◯	**Upper Endoscopy**	Date: ______	Findings: ______
◯	◯	**ERCP** (endoscopic retrograde cholangiopancreatography)	Date: ______	Findings: ______
◯	◯	**EUS** (endoscopic ultrasound)	Date: ______	Findings: ______
◯	◯	**CT scan of abdomen or GI tract** (past 6 months)	Date: ______	Findings: ______
◯	◯	**Ultrasound of abdomen or GI tract** (past 6 months)	Date: ______	Findings: ______

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SURGERIES

Please mark all surgeries you have had.

◯ I HAVE HAD NO SURGERIES

◯ Gallbladder Removal	◯ Heart Valve Replacement	◯ Hiatal Hernia Surgery	◯ Kidney Transplant
◯ Lysis of Adhesions	◯ Liver Transplant	◯ Shoulder Surgery	◯ Back Surgery
◯ Pacemaker Placement	◯ Hip Replacement	◯ Weight Loss	◯ Brain Surgery
◯ Aortic Aneurysm Repair	◯ Gastric Resection	◯ Hysterectomy	◯ Stomach Ulcer
◯ Coronary Artery Bypass Graft	◯ Knee Replacement	◯ Appendectomy	◯ TURP
◯ Automatic Cardiac Defibrillator	◯ Breast Augmentation	◯ Colon Resection	◯ **Other**

OTHER PAST OPERATIONS OR MEDICAL PROBLEMS

(Not noted elsewhere in this form.)

____

____

REFERRING DOCTOR

____

PRIMARY DOCTOR

____

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Direction of Feed

Patient Medical History

Please answer every question

*STAFF: Responses in boxed bubbles and handwritten items must be entered **MANUALLY**.*

PERSONAL AND SOCIAL HISTORY

Patient Name: ____________________

ALCOHOL USE

Question			
Do you consume alcohol?	never ◯	in the past ◯	currently ◯
Average number of drinks per week (now or in past)**?**	7 or less ◯	8-14 ◯	15 or more ◯

TOBACCO USE

Question			
How would you describe your cigarette smoking?	never ◯ / in the past ◯	currently (every day) ◯	currently (some days) ◯
How many packs per day do you (or did you) **smoke?**	less than 1 ◯	1-2 ◯	more than 2 ◯
How many years have you (or did you) **smoke?**	5 or less ◯	6-10 ◯	more than 10 ◯
Do you use other tobacco products?	never ◯	in the past ◯	currently ◯

CAFFEINE USE

Question				
How many caffeinated beverages do you consume per day?	none ◯	occasional ◯	1-2 ◯	3-5 ◯	more than 5 ◯

OTHER

Question			
IV drug use or other recreational drug use?	never ◯	in the past ◯	currently ◯
Have you engaged in high risk behavior for sexually transmitted diseases (anal sex, unprotected sex, multiple partners)**?**	never ◯	in the past ◯	currently ◯

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Question		
Have you ever had a blood transfusion?	yes ◯	no ◯
Have you had any recent foreign travel?	yes ◯	no ◯
Do you have any body piercings?	yes ◯	no ◯
Do you have any tattoos?	yes ◯	no ◯
Do you live alone?	yes ◯	no ◯

ALLERGIES

Please mark any of these allergies you have:

- Contrast or Iodine Allergy ◯
- Latex Rubber Allergy ◯
- Anaphylactic or Other Reaction to Anesthesia ◯

I HAVE NO KNOWN MEDICATION ALLERGIES ◯

MEDICATION ALLERGIES

Please list all medications or injections that have given you bad reactions.

If possible, include your reactions (e.g., hives, welts, rash, itching, headaches, nausea, diarrhea, passed out, shock, shortness of breath, etc.)

Medication or Injection	Reaction	Medication or Injection	Reaction

PRESCRIPTION MEDICATIONS

Please list all prescription medications you are currently taking.

(Alternatively, bring in an accurate list to your appointment.)

please fold on dotted line

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

OVER-THE-COUNTER MEDICATIONS

Please list all over-the-counter medications you are currently taking.

(e.g., aspirin, Motrin, Tagamet-HB, vitamins, herbs, etc.)

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

PREFERRED PHARMACY ____________________

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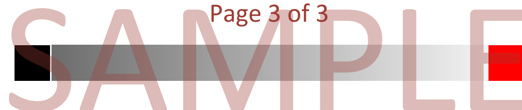

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