HEALTH HISTORY FORM FOR GASTROENTEROLOGY ASSOCIATES OF N.J

Today's Date _____ Patient's Name _____ Age _____ Referred by _____

GASTROINTESTINAL DISORDERS/SYMPTOMS

Upper GI	Explain any yes answers
Change in appetite	☐YES ☐NO
Early satiety (feeling of fullness)	☐YES ☐NO
Difficulty swallowing	☐YES ☐NO
Indigestion/gas/belching	☐YES ☐NO
Nausea/vomiting	☐YES ☐NO
Heartburn/regurgitation	☐YES ☐NO
Stomach pain (before or after meals)	☐YES ☐NO
Ulcers	☐YES ☐NO
Gallbladder disease	☐YES ☐NO
Liver disease (jaundice,hepatitis, cirrhosis)	☐YES ☐NO
Pancreatitis	☐YES ☐NO
Lower GI	
Abdominal pain/cramping	☐YES ☐NO
Gas/bloating	☐YES ☐NO
Lactose intolerance	☐YES ☐NO
Change in bowel habits	☐YES ☐NO
Constipation	☐YES ☐NO
Diarrhea	☐YES ☐NO
Rectal bleeding/hemorrhoids	☐YES ☐NO
Mucus in stools	☐YES ☐NO
Fecal incontinence	☐YES ☐NO
Inflammatory bowel disease	☐YES ☐NO
Crohn's/ulcerative colitis	☐YES ☐NO
Celiac Disease	☐YES ☐NO
Irritable bowel syndrome/spastic colon	☐YES ☐NO
Diverticulosis/diverticulitis	☐YES ☐NO
Colon polyps	☐YES ☐NO
Gastrointestinal cancer	☐YES ☐NO

PREVIOUS GI TESTING (When and Where)

Blood tests _____
Stool tests _____
Abdominal x-rays or CAT scan _____
Upper GI series/barium swallow _____
Lower GI series/barium enema _____
Sigmoidoscopy _____
Colonoscopy _____
Upper Endoscopy _____
Gallbladder tests _____

OB HISTORY

Full Term____ # Miscarriages ____ #Abortions _____

LIST MEDICATIONS & DOSAGE:

(continue on back if you need more space)
☐ No medications

Do you have any allergies (including medication, food environmental, and reaction to previous blood transfusion)
☐ YES ☐ NO If yes, describe:

Medical Conditions you have had and/or are being treated for: (i.e. heart disease, lung disease, hypertension, etc.) Continue on back if needed

SURGERIES/HOSPITALIZATIONS

Year/type continue on back if you need more space

☐ No Surgeries

Have you had any problems with anesthesia?
☐YES ☐NO If yes, please list:

PERSONAL HABITS:		
Tobacco	☐YES ☐NO	____ pk/day
Alcohol	☐YES ☐NO	____ oz/day/wk
Caffeine	☐YES ☐NO	____ cups/day
Recreational drugs	☐YES ☐NO	____ year started kind:

Family History:

	Age	current or past medical conditions:		Age	medical conditions
Mother	____	_____	Sibling M/F	____	_____
Father	____	_____	Sibling M/F	____	_____
Sibling M/F	____	_____	Sibling M/F	____	_____
Sibling M/F	____	_____	Sibling M/F	____	_____

Indicate if your parents, brothers, sisters, and/or children have a history of:

Colon Polyps ☐	Pancreas Cancer ☐	Heart Disease ☐	Colon Cancer ☐	Ulcerative Colitis ☐
Hypertension ☐	Crohn's ☐	Stomach Ulcers ☐	Lung Disease ☐	Liver disease ☐
Stomach Cancer ☐	Diabetes ☐	Celiac Disease ☐	Kidney Disease ☐	Thyroid Disorder ☐

Signature _____ Reviewed by _____