GANJ
GASTROENTEROLOGY
ASSOCIATES OF NEW JERSEY

HEALTH HISTORY FORM FOR GASTROENTEROLOGY ASSOCIATES OF NJ

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

GASTROINTESTINAL DISORDERS/SYMPTOMS

Upper GI	**Explain any yes answers**
Changes in appetite	YES ☐ NO ☐
Early satlety (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 ☐	Hearth 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 _____