

# HEALTH HISTORY FORM FOR GASTROENTEROLOGY ASSOCIATES OF ITHACA, PC

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Age \_\_\_\_\_

Referred by \_\_\_\_\_

## GASTROINTESTINAL DISORDERS/SYMPTOMS

### Upper GI

Explain any yes answers

- |  |  |
|--|--|
| Change in appetite                             | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Early satiety (feeling of fullness)            | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Difficulty swallowing                          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Indigestion/gas/belching                       | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Nausea/vomiting                                | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Heartburn/regurgitation                        | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Stomach pain (before or after meals)           | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Ulcers   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Gallbladder disease                            | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Liver disease (jaundice, hepatitis, cirrhosis) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Pancreatitis                                   | <input type="checkbox"/> YES <input type="checkbox"/> NO |

### Lower GI

- |  |  |
|--|--|
| Abdominal pain/cramping                | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Gas/bloating                           | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Lactose intolerance                    | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Change in bowel habits                 | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Constipation                           | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diarrhea                               | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Rectal bleeding/hemorrhoids            | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Mucus in stools                        | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Fecal incontinence                     | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Inflammatory bowel disease             | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Crohn's/ulcerative colitis             | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Celiac Disease                         | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Irritable bowel syndrome/spastic colon | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diverticulosis/diverticulitis          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Colon polyps                           | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Gastrointestinal cancer                | <input type="checkbox"/> YES <input type="checkbox"/> 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            | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ pk/day             |
| Alcohol            | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ oz/day/wk          |
| Caffeine           | <input type="checkbox"/> YES <input type="checkbox"/> NO | _____ cups/day           |
| Recreational drugs | <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/>   | Pancreas Cancer <input type="checkbox"/> | Heart Disease <input type="checkbox"/>  | Colon Cancer <input type="checkbox"/>   | Ulcerative Colitis <input type="checkbox"/> |
| Hypertension <input type="checkbox"/>   | Crohn's <input type="checkbox"/>         | Stomach Ulcers <input type="checkbox"/> | Lung Disease <input type="checkbox"/>   | Liver disease <input type="checkbox"/>      |
| Stomach Cancer <input type="checkbox"/> | Diabetes <input type="checkbox"/>        | Celiac Disease <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Thyroid Disorder <input type="checkbox"/>   |

Signature \_\_\_\_\_ Reviewed by \_\_\_\_\_