GASTROENTEROLOGY ASSOCIATES

Medical History

Today's Date _____

Name: **Date of Birth:**

	Yes	No
Do you currently smoke cigarettes? Packs per day _____ x _____ years	☐	☐
If you quit smoking how long ago did you quit? _____ How long did you smoke?_____		
Do you use tobacco / chew _____? Cigarettes / cigars	☐	☐
Do you drink alcohol? How much? _____ How often? _____	☐	☐
WOMEN — Are you or could you be pregnant? When was your last menstrual period? _____	☐	☐

Do you now experience or have you ever experienced: ***(Check if yes)***

1. Chest pain (angina) ☐
2. Palpitations (irregular heartbeat) ☐
3. Heart attack ☐
4. Heart murmur ☐
5. Rheumatic fever ☐
6. Congestive heart failure ☐
7. Other heart problems ☐
8. High blood pressure ☐
9. Asthma ☐
10. Emphysema ☐
11. Shortness of breath ☐
12. Tuberculosis ☐
13. Pneumonia/bronchitis ☐
14. Abnormal chest x-ray ☐
15. Recent or current cold/contagious illness ☐
16. Chronic cough ☐
17. Diabetes controlled by: ☐
    ☐ Diet ☐ Insulin ☐ Pills
18. Glaucoma ☐
19. Seizures (epilepsy) ☐
20. Stroke ☐
21. Paralysis ☐
22. Fainting spells ☐
23. Frequent headaches ☐
24. Other neurologic problems ☐
    Describe: _____
25. Mental illness ☐
    Describe: _____
26. Stomach ulcers ☐
27. Hepatitis/jaundice ☐
28. Cirrhosis/other liver disease ☐
29. Hiatal hernia/heartburn ☐
30. Difficulty swallowing ☐
31. Bowel problems ☐
32. Broken bones ☐
    ☐ Face ☐ Neck ☐ Back
33. Chronic back pain ☐
34. Arthritis ☐
35. Bruising or bleeding easily ☐
36. Kidney disease: ☐
    ☐ Infections ☐ Stones ☐ Failure
37. Cancer ☐
38. Blood transfusions ☐
39. Reactions to transfusion ☐
40. Blood clots ☐
41. Anemia ☐

Please explain any "Yes" responses:

_____

_____

_____

_____

_____

_____

_____

Do you have a family history of cancer of the stomach, intestines, pancreas, liver or colon? ☐ No ☐ Yes If yes, please specify:

Signed: Date:

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Today's Date _____

Name: _____ **Date of Birth:** _____

List all previous operations and approximate dates:

Operation	Approximate Date	Operation	Approximate Date

List current medical illnesses or conditions:

Illness	Illness

Continued from other side, Prescription and Non-Prescription:

Medication Name	Dosage	How Often	Last Dose

Please list and explain all your ALLERGIES **OR** sensitivities to medications, foods or other substances.
