

Gastroenterology Associates

Gastroenterology and Hepatology

www.gastroassociates.org

PATIENT HEALTH HISTORY FORM

(Please print clearly and complete both sides)

Patient Name: _____ Age: _____ Occupation: _____

Partner/Spouse Status: _____ Primary Care Provider: _____

The reason for your visit today: _____

Approximate date the problem started: _____

Are you having any of the following symptoms:

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty when swallowing (food sticking)? For how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn? For how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea? For how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting of food or fluid? For how long and how often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain or distress? For how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is pain worse or better with eating? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the pain related to position or activity:
<input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Lying Down |
| <input type="checkbox"/> | <input type="checkbox"/> | How frequently do you have bowel movements? _____
Is pain: <input type="checkbox"/> Aggravated or <input type="checkbox"/> Relieved by bowel movements? (mark one if applicable) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hard stools? For how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Loose or watery stools? For how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you pass stool when you don't want to? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have bowel movements that wake you up from sleep? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you seen blood in your stools? What color? _____ For how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rectal pain? |

Other History:

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had previous gastrointestinal x-rays and/or procedures in the last 3 years? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had liver or gallbladder problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a pancreas problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | What is your present weight? _____ One year ago? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you on a special eating program? If yes, what is it and under whose recommendation? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are there foods, activities or things that make you feel better or worse? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink coffee? If yes, how many cups per day? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol (including beer & wine)? Date/Time of Last Drink: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have more than 2 drinks (containing alcohol) per day? How often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have more than 12 drinks (containing alcohol) per week? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink milk? If yes, how many 8 oz. cups per day? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke or chew tobacco? If so, how much? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take aspirin, Aleve, Ibuprofen, or other pain medicine? If so, which ones and how often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take antacids or any type of stomach medicine? (Prilosec, Zantac, etc.) If so, which ones and how often? _____
What medications have you tried that <i>did</i> work? _____
What medications have you tried that <i>did not</i> work? _____ |

