

Name _____ DOB _____

Address _____

patient label here

Daytime Phone _____ Home Cell Work (Circle one)

GASTROENTEROLOGY OF EVANGELICAL

MEDICAL HISTORY FORM

Month/Year Last Flu Shot _____ Last Pneumonia Shot _____

Family MD _____

PRESENT ILLNESS AND DURATION:

1. SCHEDULED PROCEDURE & DATE:

2. If you are under regular medical care, list reason and duration:

3. Height _____ Weight _____

4. FEMALE PATIENTS:

Date of last menstrual period _____

Are you now pregnant or is there a possibility you may be pregnant yes no

5. MALE PATIENTS:

Prostate disorder yes no

6. LUNG DISEASE:

Asthma yes no

Emphysema yes no

Bronchitis yes no

Pneumonia yes no

Tuberculosis yes no

Daily cough yes no

Productive cough yes no

Shortness of breath yes no

Wheezing yes no

Are you able to walk up 2 flights of stairs without shortness of breath? yes no

7. TUMORS:

Cancer/Malignancy yes no
Treatment Chemo/Surgery/Radiation

8. CARDIOVASCULAR DISEASE:

High blood pressure yes no

Stent or cardiac surgery (date _____) yes no

Abnormal pulse/rhythm yes no

Chest pain/tightness yes no

Ankle swelling/edema yes no

Peripheral vascular disease yes no

Elevated cholesterol yes no

Circulation problems murmur yes no

Angina yes no

Palpitations yes no

Heart attack yes no

History rheumatic fever yes no

Echocardiogram (date/place _____) yes no

Stress test (date/place _____) yes no

Last EKG (date/place _____)

9. BLOOD DISORDERS:

Anemia yes no

Abnormal blood count yes no

Bleeding tendencies yes no

10. INFECTIOUS DISEASE:

Hepatitis yes no

HIV/AIDS yes no

MRSA yes no

11. DIGESTIVE DISORDER:

History of Ulcer yes no

Abdominal pain yes no

Change in stool habits yes no

Difficulty swallowing yes no

Nausea/Vomiting yes no

Hiatal hernia/Reflux/Heartburn yes no

Rectal Bleeding yes no

Liver disease yes no

Irritable Bowel Disease/Syndrome yes no

Celiac Disease yes no

Have you used Reflux/Heartburn Medication in the past? yes no

If so What? _____

12. KIDNEY/BLADDER DISEASE:

Kidney infection yes no

Pain on urination yes no

Kidney failure/Dialysis yes no

Blood in urine yes no

13. METABOLIC/ENDOCRINE:

Diabetes yes no

Thyroid disorder yes no

Adrenal Problems yes no

14. EYE, EAR, NOSE, & THROAT:

Hearing problems yes no

Glaucoma yes no

Dentures/Caps/Appliances yes no

15. NEUROMUSCULAR DISEASE:

Seizures/Convulsions yes no

Stroke/Paralysis/TIA yes no

Abnormal muscular weakness yes no

Wheelchair, Cane, Walker Use yes no

16. PSYCHOLOGICAL:

Depression yes no

Anxiety yes no

OVER

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GASTROENTEROLOGY OF EVANGELICAL MEDICAL HISTORY FORM

17. BONE/JOINT DISEASE:

- TMJ yes no
- Back problems/Disc Disease yes no
- Arthritis yes no
- Joint pain/swelling/warmth yes no
- Recent fractured bones yes no
- Specify:
- Prolonged Prednisone/Steroid use yes no
- Neck mobility/problem yes no

24. LIST ALL MEDICATIONS YOU ARE NOW TAKING

(include prescription, over the counter, herbal)
 NONE

Medication	Dosage/Freq
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

18. OTHER MEDICAL CONDITIONS:

Has your Doctor ever told you that you need antibiotics prior to a procedure yes no
If yes, Why? _____

19. SOCIAL HISTORY:

Do you live alone? yes no
Do you consume alcohol regularly? yes no
If yes, how much daily? _____
Have you ever abused any drugs? yes no
Please specify: _____

20. TOBACCO HISTORY:

Have you ever smoked regularly?
 yes no now
Quantity: _____ packs/day and duration _____ years
If you've quit, when did you last smoke? _____

25. ALLERGIES:

Have you ever been told you have an allergy?
 none latex IV contrast shellfish eggs
 others (list allergy and reaction)

21. ANESTHESIA:

Unusual/Complicated Anesthesia yes no
Malignant Hyperthermia yes no
Do you have sleep apnea? yes no
Do you use oxygen at home yes no
If yes, do you use oxygen at night? yes no
Do you use a CPAP at night? yes no
History of loud snoring? yes no
History of daytime sleepiness? yes no

26. FAMILY HISTORY:

(list relationship to you)
Heart disease
Stroke
Asthma
Diabetes
High blood pressure
Cancer (specify)
Colon Cancer or Polyps (Specify)
Ulcerative Colitis
Irritable Bowel Syndrome

22. PAST HOSPITALIZATIONS:

NONE
List year and reason (most recent first)
1)
2)
3)
4)

27. Date and Location Last Colonoscopy _____

23. PREVIOUS OPERATIONS:

NONE
List year, reason, hospital (most recent first)
1)
2)
3)
4)

28. Have you recently fallen (Fall Risk Assessment) _____

FOR INTERNAL USE ONLY

Reviewed by: _____

Date: _____