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PATIENT HISTORY FORM

Name: ____ Date: ____________________

Age: ______ Height: _______ Weight: ________ Referring Doctor: __________________

I. MAIN COMPLAINT – THE MAIN REASON(S) YOU ARE SEEING THE DOCTOR TODAY:

___ Abnormal liver test
___ Painful Swallowing
___ Positive Stool Test
___ Weight Loss
___ Lower Abdominal pain
___ Difficulty Swallowing
___ Constipation
___ Bloating
___ Blood in stool
___ Fever
___ Upper abdominal pain
___ GERD/Heartburn/Indigestion
___ Diarrhea
___ Nausea
___ Changes in bowel habits
___ Hepatitis
___ Vomiting

II. OTHER SYMPTOMS YOU ARE HAVING: PLEASE CIRCLE YES OR NO

Bloating: yes / no
Blood in stool: yes / no
Difficulty swallowing: yes / no
Change in bowel habits: yes / no
Lower abdominal pain: yes / no
Upper abdominal pain: yes / no
Diarrhea: yes / no
Fever: yes / no
Nausea: yes / no
Constipation: yes / no
Painful swallowing: yes / no
Weight Loss: yes / no
Other: ____

What specific concerns or questions would you like the physician to address?

III. REVIEW OF SYSTEMS – IF YOU ARE CURRENTLY EXPERIENCING OR HAVE RECENTLY EXPERIENCED ANY: PLEASE CIRCLE YES OR NO

CONSTITUTIONAL
Fatigue: yes / no
Fever: yes / no
Appetite loss: yes / no
Weight loss: yes / no
Weight gain: yes / no
Other: __________

CARDIOVASCULAR
Chest pain: yes / no
Edema: yes / no
Palpitations: yes / no
Short of breath: yes /no
Other: ___________

NEUROLOGICAL
Weakness: yes / no
Headaches: yes / no
Other: __________

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ENT
Bad breath: yes / no
Hoarseness: yes / no
Nose bleed: yes / no
Post nasal drip: yes / no
Sore throat: yes / no
Other: _______________

GENITOURINARY
Frequent urination: yes / no
Painful urination: yes / no
Other: __________________

PSYCHIATRIC
Anxiety Disorder: yes/ no
Depression: yes / no
Other: _______________

GYNECOLOGY
Chance of pregnancy: yes / no

ENDOCRINE
Dry skin: yes / no
Heat/Cold Intolerance: yes / no
Other: _________________

RESPIRATORY
Cough: yes / no
Short of breath: yes / no
Wheezing: yes / no
Other: yes / no

MUSCULOSKELETAL
Back pain: yes / no
Joint pain: yes / no
Other: __________

HEMATOLOGIC/LYMPHATIC
Anemia: yes / no
Bruise easily: yes / no
Tendency: yes / no
Enlarged lymph nodes: yes / no
Other: yes / no

IV: GENERAL MEDICAL HISTORY
Check if applicable

___ Arthritis
___ High Blood Pressure
___ Heart valve replacement
___ Lung Disease
___ Coronary Angioplasty (Balloon)
___Cardiac Catheterization
___ Renal Disease
___ Use of Blood Thinners
___ Heart Stents
___ Heart Attack

___ Diabetes
___ Dialysis
___Heart Murmur
___ Pacemaker
____ Valve Surgery
___ Asthma
___ Use of home oxygen
-- Dates: __________
-- Date(s): ________

___ Collagen Vascular Disease
___ Kidney Disease
___ Mitral Valve Prolapse
___ Defibrillator
___ Coronary Bypass Surgery
___ Stroke / epilepsy

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V. GI PAST MEDICAL HISTORY: PLEASE CIRCLE YES OR NO

Have you ever had:

Colonoscopy: yes / no
Colon polyp(s): yes / no
Colon cancer: yes / no
GI bleed: yes / no
Ulcer disease: yes / no
Liver disease: yes / no
Irritable bowel syndrome: yes / no
Irritable bowel disease: yes / no
Ulcerative colitis: yes / no
Crohn's Disease: yes / no
GERD: yes / no
Pancreatitis: yes / no

VI: PAST SURGICAL HISTORY

Please list all operations you have undergone:

____
____
____
____

VII: MEDICATIONS

Please list all your current medications:

Medications	Dosage	Frequency

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VIII: ALLERGIES:

Have you ever experienced an adverse reaction (i.e.: low blood pressure / heart rate, difficulty breathing, etc.) to intravenous sedation or anesthesia? Yes ____. No _____

If yes, for what operation/procedure? ____
Date of procedure? ____
Please describe the reaction: ____
____

Please list any allergies, if known

Allergic to:	Reaction:

VIIII: RECREATIONAL USE:

Do you use alcohol? Yes / No Amount: ________________ Frequency: ______________
Do you use tobacco? Yes / No Packs per day: __________ Frequency: ______________
Do you use marijuana? Yes / No Type: __________________ Frequency: ______________
Do you vape? Yes / No Type: __________________ Frequency: ______________
Do you use illicit drugs? Yes / No Type: __________________ Frequency: ______________

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