Metropolitan Gastroenterology Assoc.

MEDICAL & FAMILY HISTORY FORM

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Height:** _____ **Weight:** _____

Referring Physician: _____ **Reason for Visit:** _____

Pharmacy: _____ **Address:** _____ **Phone:** _____

ALLERGIES

❑ None ❑ Aspirin ❑ Codeine ❑ Demerol ❑ Penicillin ❑ Propofol/Diprivan
❑ Versed ❑ IV Contrast or iodine ❑ Latex ❑ Eggs ❑ Nuts
❑ Sulfa ❑ Other Allergies: _____

PAST OR PRESENT MEDICAL CONDITIONS

General

❑ None
❑ Anemia ❑ Blood clotting problems ❑ High blood pressure ❑ Sleep apnea
❑ Cataracts ❑ Heart attack ❑ Cardiac arrhythmia ❑ Stroke
❑ Emphysema ❑ Pneumonia ❑ Asthma ❑ Diabetes
❑ Thyroid disease ❑ Convulsions/Seizures ❑ Kidney disease ❑ Back problems
❑ Blood transfusion(s) ❑ Anxiety disorder ❑ Depression ❑ Arthritis
❑ Glaucoma ❑ Gout ❑ Other General Conditions: _____

Cancer

❑ None
❑ Cervical/Uterine cancer ❑ Breast cancer ❑ Colon cancer ❑ Prostate cancer
❑ Esophageal cancer ❑ Liver cancer ❑ Lung cancer ❑ Other Cancer: _____

Gastrointestinal

❑ None
❑ Celiac sprue ❑ Acid reflux/Heart burn ❑ Peptic ulcer disease ❑ Ulcerative colitis
❑ Crohn's disease ❑ Diverticulitis ❑ Diverticulosis ❑ Colon polyps
❑ Irritable bowel syndrome ❑ Gallstones ❑ Cirrhosis of liver ❑ Other liver disease
❑ Hemorrhoids ❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C
❑ Pancreatitis ❑ Other GI Conditions: _____

PREVIOUS SURGERIES • PROCEDURES • HOSPITALIZATIONS

❑ None

❑ Tonsils date: _____ ❑ Appendix removal date: _____ ❑ Prostate date: _____ ❑ Joint surgery date: _____ ❑ Implanted defibrillator (ICD) date: _____
❑ Cardiac bypass date: _____ ❑ Heart valve replacement date: _____ ❑ C-section date: _____ ❑ Hysterectomy date: _____ ❑ Ovary removal date: _____
❑ Breast date: _____ ❑ Gastric bypass/Surgery date: _____ ❑ Gall bladder removal date: _____ ❑ Colon resection date: _____ ❑ Colostomy date: _____
❑ Tubal ligation date: _____ ❑ EGD date: _____ ❑ Sigmoidoscopy date: _____ ❑ Colonoscopy date: _____ ❑ Capsule endoscopy date: _____
❑ ERCP date: _____ ❑ Other (please include dates): _____

SOCIAL HISTORY

Occupation: _____ Number of Children: _____

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
❑ Civil union ❑ Other: _____

------ Alcohol Consumption ------

❑ None
❑ Beer qty.: _____ frequency: _____ ❑ Wine qty.: _____ frequency: _____
❑ Liquor qty.: _____ frequency: _____ ❑ Prior history of >10 drinks/week qty.: _____ frequency: _____

------ Tobacco and Drug Use ------

❑ Current everyday smoker ❑ Current some day smoker ❑ Former smoker ❑ Never smoked
❑ Cigarettes qty.: _____ frequency: _____
❑ Cigars qty.: _____ frequency: _____
❑ Other: _____ qty.: _____ frequency: _____

❑ No drug use ❑ Recreational drug user

MEDICATIONS

Name of Medication	Strength	How Often	Name of Medication	Strength	How Often

FAMILY HISTORY

	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather
Deceased at age	_____	_____	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____	_____	_____
Bile duct cancer	❑	❑	❑	❑	❑	❑	❑	❑
Bladder cancer	❑	❑	❑	❑	❑	❑	❑	❑
Breast cancer	❑	❑	❑	❑	❑	❑	❑	❑
Colitis	❑	❑	❑	❑	❑	❑	❑	❑
Colon cancer	❑	❑	❑	❑	❑	❑	❑	❑
Colon polyps	❑	❑	❑	❑	❑	❑	❑	❑
Crohn's disease	❑	❑	❑	❑	❑	❑	❑	❑
Esophageal cancer	❑	❑	❑	❑	❑	❑	❑	❑
Female organ cancer	❑	❑	❑	❑	❑	❑	❑	❑
Heart problems	❑	❑	❑	❑	❑	❑	❑	❑
Liver disease	❑	❑	❑	❑	❑	❑	❑	❑
Pancreatic cancer	❑	❑	❑	❑	❑	❑	❑	❑
Skin cancer	❑	❑	❑	❑	❑	❑	❑	❑
Small intestine cancer	❑	❑	❑	❑	❑	❑	❑	❑
Stomach cancer	❑	❑	❑	❑	❑	❑	❑	❑

REVIEW OF SYSTEMS

Please indicate if your are experiencing, or have experienced **in the last six (6) months**:

Cardiovascular
- ❑ Irregular heart beat
- ❑ Palpitations
- ❑ Passing out
- ❑ Angina/chest pressure with activity
- ❑ Ankle swelling

Constitutional
- ❑ Weight gain
- ❑ Weight loss
- ❑ Fever

Ear Nose Mouth and Throat
- ❑ Nose bleeds
- ❑ Eye pain
- ❑ Change in vision
- ❑ Dry eyes
- ❑ Bleeding gums
- ❑ Hoarseness
- ❑ Mouth sores

Endocrine
- ❑ Excessive thirst
- ❑ Cold intolerance

Respiratory
- ❑ Chronic cough
- ❑ Shortness of breath

Gastrointestinal
- ❑ Abdominal pain
- ❑ Black stool
- ❑ Change in bowel habits
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas
- ❑ Heartburn
- ❑ Jaundice
- ❑ Nausea
- ❑ Vomiting
- ❑ Belching
- ❑ Bloating
- ❑ Blood in stool
- ❑ Incontinence to stool
- ❑ Loss of appetite
- ❑ Milk intolerance
- ❑ Trouble swallowing
- ❑ Pain with bowel movement
- ❑ Painful swallowing
- ❑ Rectal bleeding

Genitourinary
- ❑ Frequent urinary infections
- ❑ Blood in urine
- ❑ Urinary incontinence

Hematologic/Lymphatic
- ❑ Prolonged bleeding
- ❑ Enlarged glands
- ❑ Use of Plavix, Coumadin or other blood thinners

Integumentary
- ❑ Itching
- ❑ Rashes

Musculoskeletal
- ❑ Back pain
- ❑ Joint pain
- ❑ Muscle pain

Neurological
- ❑ Seizures
- ❑ Headaches
- ❑ Stroke or paralysis

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Memory loss