

Date _____

Gastroenterology and Hepatology Specialists, Inc.
SCREENING MEDICAL HISTORY FORM

You are asked to fill this form out as completely as you can. These questions are a necessary part of the examination; at a glance the doctor will obtain essential data about you, enabling him more time for concentration on your areas of concern. If you have any question, please do not call the office, but leave the area in question blank.

DO NOT MAIL
BRING PAPERS WITH YOU

General Information:

Name _____

Address _____

Date of Birth _____ Age _____ Marital Status _____ SS Number _____

Home Phone _____ Business Phone _____ Where Employed _____

Health Insurance Carrier _____

Referring Physician and Address _____

_____ Phone Number _____

Next of Kin _____ Phone Number _____

If you were not referred to us by a physician, please tell us who referred you or why you contacted us.

List briefly your **chief complaint** and its' duration:

Personal Information:

Coffee _____ Tea _____ Tobacco _____ for _____ years _____ Liquor or alcohol _____ / _____
Cups daily Cups daily Packs per day # oz. daily oz. weekly

Beer _____ / _____ Wine _____ / _____ Recreational Drug Use _____ and _____ / _____
Bottles per day/week Glasses per day/week Name of drug times per day/week

Soft Drinks _____ Herbs usage _____
Bottles per day Name and how many times per day

Over The Counter Medications _____
Name and how many times per day

Diet Gum/Candy _____ Tattoos/Body Piercings _____
Name and how many times per week How many and for how long

Are you presently taking any of the following medications?(Please check the medication even if you take it infrequently)

- | | | |
|--|--|---|
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Vioxx | <input type="checkbox"/> Bufferin |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Midol | <input type="checkbox"/> Vanquish |
| <input type="checkbox"/> Coricidin | <input type="checkbox"/> Anacin | <input type="checkbox"/> Arthritis Pain Formula |
| <input type="checkbox"/> Excedrin | <input type="checkbox"/> Empirin Cmpd | <input type="checkbox"/> Pepto Bismol |
| <input type="checkbox"/> PAC or APC | <input type="checkbox"/> Alka Seltzer | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Darvon Cmpd | <input type="checkbox"/> Bromo Seltzer | <input type="checkbox"/> Blood Pressure Pills |
| <input type="checkbox"/> Cope | <input type="checkbox"/> Birth Control | <input type="checkbox"/> Nuprin |
| <input type="checkbox"/> Clinoril | <input type="checkbox"/> Advil | <input type="checkbox"/> Meclomen |
| <input type="checkbox"/> Motrin | <input type="checkbox"/> Nalfon | <input type="checkbox"/> Orudis |
| <input type="checkbox"/> Ansaid | <input type="checkbox"/> Voltaren | <input type="checkbox"/> Dolobid |
| <input type="checkbox"/> Indocin | <input type="checkbox"/> Relafen | |
| <input type="checkbox"/> Antibiotics (past 3 months) | | |

List all medications you take regularly:

Name	Dosage	Frequency

List any drug allergies:

Height _____ Weight _____ Any weight changes in the last 6 months? _____

Approximate date of last:

- | | |
|------------------------------------|-------------------------|
| Gallbladder Xray _____ | Complete Physical _____ |
| UGI Series _____ | Chest X-ray _____ |
| Barium Enema _____ | Electrocardiogram _____ |
| Sigmoidoscopy _____ | PAP Smear _____ |
| Colonoscopy _____ | Mammogram _____ |
| Stool check for occult blood _____ | Chemistry _____ |
| Prostate Blood Test _____ | Lipid Profile _____ |

List all operations and hospitalizations in chronological order:

Date	Diagnosis/Operation	Hospital	Doctor

Have you ever had or been treated for (check the problem concerned)?

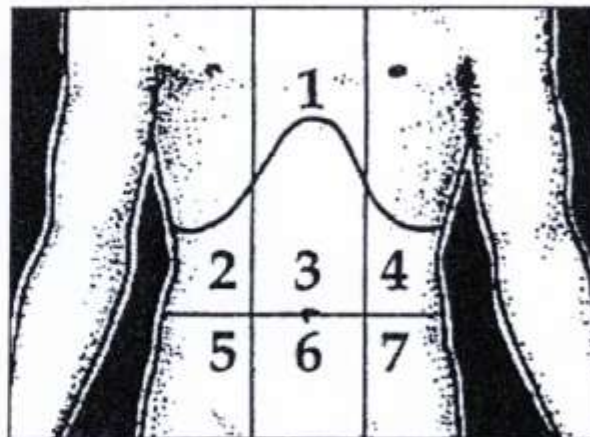
- | | | |
|---|---|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Valve Replacement |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Enlarged Heart | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Coronary artery bypass graft | |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> TB | <input type="checkbox"/> Chronic bronchitis |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Duodenal Ulcer-Gastric Ulcer | <input type="checkbox"/> Nausea | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Heart Burn | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Rectal Gas | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Belching | |
| <input type="checkbox"/> Blood, pus or protein in urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Nephritis |
| <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Kidney or bladder infection (cystitis) | |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Seizures | <input type="checkbox"/> Financial problems |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Nervousness | <input type="checkbox"/> In-law problems |
| <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Periods of depression |
| <input type="checkbox"/> Knee replacement | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Marital and/or sexual problems | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Impotence or decreased sex drive | <input type="checkbox"/> Alcohol or substance abuse |

Please check YES or NO:

- | | | |
|--------------------------------------|--------------------------|--------------------------|
| Do you ever have trouble swallowing? | YES | NO |
| Liquids? | <input type="checkbox"/> | <input type="checkbox"/> |
| Solids? | <input type="checkbox"/> | <input type="checkbox"/> |
| Infrequently? | <input type="checkbox"/> | <input type="checkbox"/> |
| Every Meal? | <input type="checkbox"/> | <input type="checkbox"/> |
| When Nervous? | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain upon swallowing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent chest pains? | <input type="checkbox"/> | <input type="checkbox"/> |

Have you recently had Pain in the stomach (check where appropriate)

- Intermittent?
- Constant?
- Dull Ache?
- Burning or Gnawing?
- Cramping?
- Brought on by fried or greasy food?
- Relieved by bowel movement or passage of gas?
- Loss of appetite?
- Nausea?
- Vomiting?
- Heartburn, chest or retrosternal?
- Heartburn? What region _____?
- Occurs one to two hours after meals?
- Awaken you at night?
- Relieved temporarily by antacids?
- Relieved by Tagamet, Zantac, Pepcid, Acid, Prilosec, Protonix, Aciphex, Nexium
(circle any that apply)
- Relieved with milk or eating?
- Occurs while eating or immediately after?



Circle area(s) or pain(s)

Other Comments:

Married? _____ How long? _____ How many times?

List names, ages, and state of health of any children:
