Please place an "X" and date any items pertaining to your medical history

(where there are multiple choices, please circle all that apply)

Patient Name

Personal Past Medical History

X	Date	Personal Past Medical History		X	Date
		Acute Pancreatitis	Last Colonoscopy		
		Anal Fissure	Last EGD		
		Anal Fistula	Liver Biopsy		
		Anemia	ERCP		
		Asthma	**Past Surgical History**		
		Appendicitis	Appendectomy		
		Arthritis	Bariatric Surgery (gastric surgery for weight loss)		
		Biliary Tract Cancer	Cholecystectomy (gallbladder removal)		
		Bleeding Disorder/hemophilia A or B	Colon Surgery		
		Christmas Disease, vonWillebrand	Exploratory laparotomy (abdominal surgery)		
		Blood in Stool	Fissurectomy (removal for fissure)		
		COPD/Emphysema	Fistulotomy (removal of fistula)		
		Celiac Disease	Fundoplication, Nissen (stomach surgery for acid reflux)		
		Chronic Pancreatitis	Gastrectomy (removal of stomach)		
		Cirrhosis of Liver	Heart Bypass Surgery (CABG)		
		Colon Cancer	Heart Attack Stents Valve Replacement		
		CHF (Congestive Heart Failure)	**(please circle above all that apply)**		
		Crohn's Disease	Hemorrhoidectomy (removal of hemorrhoids)		
		Coronary Heart Disease	Hernia Repair		
		Diabetes	Hysterectomy (female surgery for uterus/ovaries)		
		Diverticulitis	Lysis of Adhesions (scar tissue on internal organs/cut)		
		Elevated Cholesterol	Pacemaker (provide copy of card for patient chart)		
		Esophageal Reflux (GERD)	Internal defibrillator (provide copy fo card for patient chart)		
		Esophageal Stenosis	Neurostimulator		
		Esophagus Cancer	**Please list any past medical history not listed above**		
		Gastric Ulcer			
		GI Tract Bleeding			
		Hematemesis (Vomiting blood)			
		Hemorrhoid			
		Hepatitis	**Allergy List**		
		Hernia	**Please check if No Known Allergies →**		
		Hypertension (High Blood Pressure)	**If Allergies, please list along with type of reaction:**		
		Irritable Bowel Syndrome	**(include medications, food, environmental)**	**Type of Reaction**	
		Liver Disorder			
		Mitral Valve Prolapse			
		Osteoporosis			
		Oxygen Use			
		Renal Failure/Kidney Disorder			
		Respiratory Disorder			
		Sleep Apnea / CPAP Machine	**Family Medical History**	**List Relationship**	
		Stroke			
		Seizure Disorder			
		Thyroid Disease			
		Ulcerative Colitis			
		Liver Disorder			
		Other Endocrine Disorder			
		Other Neurologic Disorder			
Any other medical problem/condition we should know:					

DOB:

DATE COMPLETED

Patient Name: **DOB:** **Date:**

Medication List

Current Medication	Reason for Medication	Dosage	Prescribing Doctor

Genetic History

	Please check any that apply	*Relationship*
	NONE	
	Cystic Fibrosis	
	Esophagus Anomalies, Congenital	
	Gallbladder, Bile Ducts, and Liver Anomalies	
	Hemochromatosis	
	Hemophilia / Bleeding disorders	
	History or Family History of Malignant Hyperthermia (Rise in body temperature during anesthesia.)	
	Other Inherited Genetic or Chromosomal Disorders	

Any other Genetic History not listed above

Review of Systems

Please circle if you are currently experiencing any of the symptoms below

	Symptoms (*please circle all that apply)*
Constitutional:	Fever, chills, weight loss
Eyes:	Blurred vision
HENT:	Sore throat, Mouth sores
Cardiovascular:	Chest Pain, Irregular heart beats, Shortness of Breath
Gastrointestinal:	Nausea, Vomiting, Diarrhea, Black Stools
Skin:	Rash, Itching
Neurologic:	Tingling or numbness, Headaches
Musculoskeletal:	Joint pain, Muscle pain
Endocrine:	Weight gain, Frequent urination
Psychiatric:	Anxiety, Depression
Heme-Lymph:	Easy bleeding, Lymph node enlargement or tenderness
Allergic-Immunologic:	Sinus allergy symptoms

Social History

Marital Status: ____________________

Tattoo: ____________________

Occupation: ____________________

Blood Transfusion:____________________ (if yes, when________________

Exercise: ____________________

Recent travel outside of US___________ (if yes, when/where)____________

Substance Use:

				Name/Type	**Amount**	**Age Started**	**Age Stopped**	**Other Information**
Tobacco	*Never*	*Current*	*Former*					
Alcohol	*Never*	*Current*	*Former*					
Caffeine	*Never*	*Current*	*Former*					
Prescription Abuse	*Never*	*Current*	*Former*					
Illegal Drugs	*Never*	*Current*	*Former*					
Other	*Never*	*Current*	*Former*					