

# HEALTH HISTORY FORM FOR GASTROENTEROLOGY ASSOCIATES OF ITHACA, PC

Today's Date \_\_\_\_\_ Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Referred by \_\_\_\_\_

GASTROINTESTINAL DISORDERS/SYMPTOMS	
Upper GI	Explain any yes answers
Change in appetite	<input type="checkbox"/> YES <input type="checkbox"/> NO
Early satiety (feeling of fullness)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Difficulty swallowing	<input type="checkbox"/> YES <input type="checkbox"/> NO
Indigestion/gas/belching	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nausea/vomiting	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heartburn/regurgitation	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stomach pain (before or after meals)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ulcers	<input type="checkbox"/> YES <input type="checkbox"/> NO
Gallbladder disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Liver disease (jaundice, hepatitis, cirrhosis)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pancreatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Lower GI	
Abdominal pain/cramping	<input type="checkbox"/> YES <input type="checkbox"/> NO
Gas/bloating	<input type="checkbox"/> YES <input type="checkbox"/> NO
Lactose intolerance	<input type="checkbox"/> YES <input type="checkbox"/> NO
Change in bowel habits	<input type="checkbox"/> YES <input type="checkbox"/> NO
Constipation	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diarrhea	<input type="checkbox"/> YES <input type="checkbox"/> NO
Rectal bleeding/hemorrhoids	<input type="checkbox"/> YES <input type="checkbox"/> NO
Mucus in stools	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fecal incontinence	<input type="checkbox"/> YES <input type="checkbox"/> NO
Inflammatory bowel disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Crohn's/ulcerative colitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Celiac Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Irritable bowel syndrome/spastic colon	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diverticulosis/diverticulitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Colon polyps	<input type="checkbox"/> YES <input type="checkbox"/> NO
Gastrointestinal cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO

LIST MEDICATIONS & DOSAGE:
(continue on back if you need more space)
<input type="checkbox"/> No medications

Do you have any allergies (including medication, food, environmental, and reaction to previous blood transfusion)

YES  NO If yes, describe:

**Medical Conditions you have had and/or are being treated for:** (i.e. heart disease, lung disease, hypertension, etc.) Continue on back if needed

SURGERIES/HOSPITALIZATIONS
Year/type continue on back if you need more space
<input type="checkbox"/> No Surgeries

**Have you had any problems with anesthesia?**

YES  NO If yes, please list:

**PREVIOUS GI TESTING (When and Where)**

Blood tests \_\_\_\_\_

Stool tests \_\_\_\_\_

Abdominal x-rays or CAT scan \_\_\_\_\_

Upper GI series/barium swallow \_\_\_\_\_

Lower GI series/barium enema \_\_\_\_\_

Sigmoidoscopy \_\_\_\_\_

Colonoscopy \_\_\_\_\_

Upper Endoscopy \_\_\_\_\_

Gallbladder tests \_\_\_\_\_

PERSONAL HABITS:		
Tobacco	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ pk/day
Alcohol	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ oz/day/wk
Caffeine	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ cups/day
Recreational drugs	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____ year started kind:

Family History: Age	current or past medical conditions:	Age	medical conditions
Mother _____	_____	Sibling M/F _____	_____
Father _____	_____	Sibling M/F _____	_____
Sibling M/F _____	_____	Sibling M/F _____	_____
Sibling M/F _____	_____	Sibling M/F _____	_____

*Indicate if your parents, brothers, sisters, and/or children have a history of:*

Colon Polyps <input type="checkbox"/>	Pancreas Cancer <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Colon Cancer <input type="checkbox"/>
Hypertension <input type="checkbox"/>	Crohn's <input type="checkbox"/>	Stomach Ulcers <input type="checkbox"/>	Lung Disease <input type="checkbox"/>
Stomach Cancer <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Celiac Disease <input type="checkbox"/>	Kidney Disease <input type="checkbox"/>
			Ulcerative Colitis <input type="checkbox"/>
			Liver disease <input type="checkbox"/>
			Thyroid Disorder <input type="checkbox"/>

Signature \_\_\_\_\_ Reviewed by \_\_\_\_\_