Health History Form

WESTSIDE Gastroenterology ASSOCIATES

Date: _____

Patient Name: _____ Date of Birth _____ Age _____
Referred by: _____ Phone # _____
Primary Care Physician: _____ Phone # _____

1. **Describe your current problem(s):**

A. _____

B. _____

2. **History of Present Illness** (your current symptoms). Check all that apply.

- ☐ Heartburn
- ☐ Trouble swallowing
- ☐ Painful swallowing
- ☐ Nausea/Vomiting
- ☐ Pain/Burning in stomach
- ☐ History of ulcers
- ☐ Vomiting blood
- ☐ Bloody stools
- ☐ Anemia (low blood count)
- ☐ Hepatitis/type _____
- ☐ Jaundice
- ☐ Liver problems
- ☐ Pancreas problems
- ☐ Gallbladder problems
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Bloating
- ☐ Flatulence
- ☐ Weight loss
- ☐ Fever
- ☐ Lack of appetite
- ☐ Family history of polyps
- ☐ Family history of colon cancer
- ☐ Family history of ulcers
- ☐ Family history of colitis
- ☐ Family history of gallstones

3**. Past History**

A. **Surgical**-Check all that apply. List year and any comments.

- ☐ Appendectomy _____
- ☐ Breast surgery _____
- ☐ Colon surgery _____
- ☐ Gallbladder surgery _____
- ☐ Heart _____
- ☐ Brain _____
- ☐ Hemorrhoidectomy_____
- ☐ Hernia repair _____
- ☐ Hysterectomy _____
- ☐ Ovaries removed _____
- ☐ Joint replacement _____
- ☐ Spine _____
- ☐ Stomach surgery _____
- ☐ Thyroid surgery _____
- ☐ Tonsillectomy _____

Other _____

B. **Medical History**-Check all that apply. List the year and any comments:

- ☐ Hepatitis _____
- ☐ Other liver disease _____
- ☐ Lung disease _____
- ☐ Heart disease _____
- ☐ High blood pressure _____
- ☐ Stomach/intestine _____
- ☐ Seizures _____
- ☐ Cancer _____
- ☐ Arthritis _____
- ☐ Psychiatric _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ Enlarged prostate _____
- ☐ Thyroid disorder _____
- ☐ High cholesterol _____
- ☐ Other _____

C. Allergies: ☐ Pcn ☐ Sulfa ☐ Codeine ☐ Latex ☐ Other _____

D. **Medications:**

Name	Strength	How often	Name	Strength	How often

E. **Do you take**:

- ☐ aspirin or arthritis medications_____
- ☐ Blood thinners-Coumadin, Plavix_____
- ☐ Herbal supplements_____

F. **Latex Allergy Screening:**

- ☐ Do you have a latex allergy?
- ☐ Do any of the following apply to you:
  - ☐ Spina Bifida?
  - ☐ Self Catheterization?
  - ☐ Urinary problems at birth?
  - ☐ Allergy to bananas, avocadoes, tropical fruits or chestnuts?
  - ☐ Have you ever had itching, rash, wheezing or watery eyes after using household rubber gloves?

If you answered YES to any of the above:

- ☐ Were you tested for latex allergy?
- ☐ Was an allergy identified?
- ☐ Specify type of allergy: _____

4. **Family History:** **F**=father **M**=mother **D**=daughter **A**=aunt
B=brother **S**=sister **S**=son **U**=uncle **G**=grandparent

Colon cancer _____
Stomach cancer _____
Colitis _____
Colon polyps _____
Crohn's _____
Diabetes _____
Gallstones _____
Heart disease _____
High blood pressure _____
Liver disease _____
Mental disease _____
Pancreatitis _____
Stroke _____
Tuberculosis _____
Ulcerative colitis _____
Stomach ulcers _____
Other _____

5**. Social History** (If yes, please indicate how much per day)

☐Smoke _____(pk/day)
☐Drink alcohol _____(oz/day)
☐Drink coffee _____(cups/day)
☐Drink tea _____(glasses/day)
☐Drink milk _____(glasses/day)
☐Drink carbonated beverages _____

6. **Review of Systems**. Check all that apply

HEENT
☐History of Nosebleeds
☐Sinus/postnasal drip
☐Ringing in ears
☐Sore Throat
☐Other _____

PULMONARY
☐Chronic cough
☐Cough up blood
☐Asthma/wheezing
☐Short of breath
☐Last flu shot_____
Last pneumonia vaccine_____

CARDIAC
☐Chest pain
☐Palpitations
☐Swollen ankles
☐Short of breath lying down
☐Last EKG _____

GI
☐Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Difficulty swallowing
☐Other _____

GU
☐Painful urination
☐Blood in urine
☐Urethral discharge
☐Urinate frequently
☐Difficulty starting stream
☐Other _____

GYN
☐Vaginal bleeding
☐Vaginal discharge
☐Lower abdominal pain
☐Irreg vaginal bleeding
☐Last mammogram _____
Last GYN exam _____

NEURO
☐Dizziness
☐Vertigo
☐TIA
☐Memory problems
☐Other _____

OPHTHALMOLOGIC
☐Red eye
☐Blurred vision
☐Painful eye
☐Blind spots
☐Other _____

ENDOCRINE
☐Hot/Cold
☐Excessive thirst
☐Excessive urination
☐Significant weight gain/loss
☐Other _____

HEMATOLOGIC
☐Tired
☐Irregular bleeding
☐Easy bruising
☐Blood clots
☐Other _____

PSYCHOLOGICAL
☐Inability to sleep
☐Panic attacks
☐Anxiety all the time
☐Inability to think
☐Other _____

DERMATOLOGIC
☐Skin rash
☐Hair loss
☐Change in skin color
☐Change in mole
☐Itching
☐Other _____

DENTAL
☐Gum bleed
☐Tooth pain
☐Bad breath
☐Sensitive teeth
☐Loss of teeth
☐Dentures/partials
☐Other _____

MUSCULOSKELETAL
☐Joint swelling
☐Joint pain
☐Pain not relieved by rest
☐Spine pain
☐Other

Height _____ Weight _____

7. **Additional information**:

_____
_____
_____

I have filled this form out to the best of my abilities as accurately as possible.

_____
Patient Signature Date

Reviewed by Initials
☐Jasmine Jeffers, MD _____