HEALTH HISTORY FORM FOR GI ASSOCIATES OF TALLAHASSEE

Today's Date _____ Patient's Name _____ Age _____ Referred By _____

GASTROINTESTINAL DISORDERS/SYMPTOMS

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

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 _____

OB HISTORY

Full Term _____ # Miscarriages _____ # Abortions _____

LIST MEDICATIONS & DOSAGE

(continue on back if you need more space)

☐ 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*

☐ No Surgeries

Have you had any problems with anesthesia?

☐ Yes ☐ No If yes, please list:

PERSONAL HABITS

Tobacco	☐ Yes ☐ No	_____ pk/day
Alcohol	☐ Yes ☐ No	_____ oz/day/wk
Caffeine	☐ Yes ☐ No	_____ cups/day
Recreational Drugs	☐ Yes ☐ 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 ☐	Pancreas Cancer ☐	Heart Disease ☐	Colon Cancer ☐	Ulcerative Colitis ☐
Hypertension ☐	Crohn's ☐	Stomach Ulcers ☐	Lung Disease ☐	Liver Disease ☐
Stomach Cancer ☐	Diabetes ☐	Celiac Disease ☐	Kidney Disease ☐	Thyroid Disorder ☐

Signature _____ Reviewed By _____

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