

# Gastroenterology of Southern Indiana

## PAST MEDICAL HISTORY

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**Your family physician is referring you to us for further evaluation. What kind of problem are you having?**

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### List Medicine/Food Allergies:

**NONE**     Aspirin     Iodine     Penicillin     Sulfa     Versed     Eggs     Latex    Other \_\_\_\_\_

### Past Illnesses:

<input type="radio"/> <b>NONE</b>	<input type="radio"/> Stomach/Duod Ulcer	<input type="radio"/> Abnormal Blood Clotting/Blood Clots	<input type="radio"/> High Cholesterol	<input type="radio"/> Emphysema/COPD
<input type="radio"/> Cirrhosis	<input type="radio"/> Ulcerative Colitis	<input type="radio"/> Anemia	<input type="radio"/> Irregular Heart Beat	<input type="radio"/> Pneumonia
<input type="radio"/> Colon Polyps	<input type="radio"/> Chronic Headache	<input type="radio"/> Blood Transfusions	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Sleep Apnea
<input type="radio"/> Crohn's Disease	<input type="radio"/> Parkinson's Disease	<input type="radio"/> HIV/AIDS	<input type="radio"/> Chronic Pain (<6 mos)	<input type="radio"/> Endometriosis
<input type="radio"/> Diverticulitis	<input type="radio"/> Seizures	<input type="radio"/> Sexually Transmitted Disease	<input type="radio"/> Fibromyalgia	<input type="radio"/> Frequent Urinary Infections
<input type="radio"/> Esophagitis/GERD	<input type="radio"/> Stroke or Paralysis	<input type="radio"/> TB or Positive TB skin test	<input type="radio"/> Lupus	<input type="radio"/> Kidney Disease/Failure
<input type="radio"/> Gallstones	<input type="radio"/> Breast Cancer	<input type="radio"/> Arterial Blockages	<input type="radio"/> Melanoma	<input type="radio"/> Kidney Stones
<input type="radio"/> Groin Hernia	<input type="radio"/> Colon Cancer	<input type="radio"/> Heart Disease	<input type="radio"/> Multiple Sclerosis	<input type="radio"/> Ovarian Cysts
<input type="radio"/> Hepatitis	<input type="radio"/> Ovarian Cancer	<input type="radio"/> Heart Failure	<input type="radio"/> Osteoporosis	<input type="radio"/> Diabetes
<input type="radio"/> Irritable Bowel	<input type="radio"/> Prostate Cancer	<input type="radio"/> Heart Murmur	<input type="radio"/> Psoriasis	<input type="radio"/> Thyroid Disease
<input type="radio"/> Pancreatitis	<input type="radio"/> Abnormal Bleeding	<input type="radio"/> High Blood Pressure	<input type="radio"/> Asthma	Other _____

### Previous Operations or Treatments:

<input type="radio"/> <b>NONE</b>	<input type="radio"/> Colonoscopy	<input type="radio"/> ERCP	<input type="radio"/> Ovary	<input type="radio"/> Tubal Ligation
<input type="radio"/> Appendectomy	<input type="radio"/> Capsule Endoscopy	<input type="radio"/> Colon Polyp Removal	<input type="radio"/> Radiation Therapy- Head/Neck	<input type="radio"/> Radiation Therapy-Chest
<input type="radio"/> Cardiac (CABG)	<input type="radio"/> C-Section	<input type="radio"/> Liver Biopsy	<input type="radio"/> Radiation Therapy- Abdomen	<input type="radio"/> Radiation Therapy-Ovary
<input type="radio"/> Cardiac (VALVE)	<input type="radio"/> Gallbladder	<input type="radio"/> Hysterectomy	<input type="radio"/> Radiation Therapy- Prostate	<input type="radio"/> Pacemaker/Defibrillator
<input type="radio"/> Colon Resection	<input type="radio"/> Groin Hernia	<input type="radio"/> Joint Replacement	<input type="radio"/> Prostate Surgery	
<input type="radio"/> Colostomy	<input type="radio"/> Hemorrhoid	<input type="radio"/> Kidney	<input type="radio"/> Stomach	
<input type="radio"/> Upper/EGD	<input type="radio"/> Hiatal Hernia	<input type="radio"/> Obesity Surgery	<input type="radio"/> Thyroid	Other _____

### Social History/Marital Status:

Single     Separated     Married  
 Divorced     Widowed

### Social History/Alcohol:

Never     Quit  
 1 or fewer  
drinks/week     2 or more drinks/week

### Social History/Tobacco:

Never     Quit  
 20 or fewer cigarettes/day     More than 1 pack/day

### Social History/Recreational Drugs Use:

Never     Currently using  
 Used in the past     Treated for substance abuse

### Social History/Occupation:

Patient Occupation \_\_\_\_\_  Veteran

ARE YOU NOW EXPERIENCING....

**Gastrointestinal:**

- NONE**       change in bowel habit       painful swallowing       painful stools       vomiting  
 abdominal pain       constipation       flatulence/rectal gas       rectal bleeding  
 belching       dairy incontinence       heartburn/reflux       rectal protrusions  
 black stools       diarrhea       mucous in stools       rectal urgency  
 bloating       difficulty swallowing       nausea       soiling/incontinence      Other \_\_\_\_\_

**Genitourinary:**

- NONE**       burning urination  
 blood in urine      Other \_\_\_\_\_

**Skin:**

- NONE**       rash  
 itching       suspicious lesions  
 jaundice      Other \_\_\_\_\_

**Cardiovascular:**

- NONE**       chest pain       shortness of breath  
 ankle swelling       irregular heartbeat      Other \_\_\_\_\_

**Neurological:**

- NONE**       frequent headaches  
 dizziness       loss of consciousness  
 fainting      Other \_\_\_\_\_

**Endocrine:**

- NONE**       heat intolerance  
 excessive thirst  
 cold intolerance      Other \_\_\_\_\_

**Constitutional:**

- NONE**       weight loss  
 fatigue       weight gain  
 fever  
 loss of appetite      Other \_\_\_\_\_

**Psychiatric:**

- NONE**       difficulty sleeping  
 anxiety/panic  
 depression      Other \_\_\_\_\_

**Eyes:**

- NONE**       visual decline  
 light sensitivity  
 eye pain      Other \_\_\_\_\_

**Hematologic:**

- NONE**       abnormal blood clotting  
 easy bruising  
 prolonged bleeding      Other \_\_\_\_\_

**Ears, Nose and Throat:**

- NONE**       sore throat  
 hearing loss       nose bleeds  
 hoarseness      Other \_\_\_\_\_

**Musculoskeletal:**

- NONE**       muscle pain  
 back pain  
 joint pain      Other \_\_\_\_\_

**Respiratory:**

- NONE**       painful breathing  
 coughing blood  
 chronic cough      Other \_\_\_\_\_

