Gastrointestinal Associates of Cleveland Medical History Form

Name: _____ **DOB:** _____ **Date:** _____

Main problem that you are being seen for: _____

Past/Current Medical History

Gastrointestinal Illnesses ❍ **None**

- ❍ Abnormal Blood Tests of Liver
- ❍ Anemia, Chronic
- ❍ Anemia, Iron Deficient
- ❍ Appendicitis
- ❍ Barrett's Esophagus
- ❍ Celiac Disease
- ❍ Cirrhosis, Alcoholic
- ❍ Cirrhosis, Non-alcoholic
- ❍ Colitis, Other _____
- ❍ Colitis, Ulcerative
- ❍ Colon Polyps
- ❍ Colon or Rectal Cancer
- ❍ Crohn's Disease
- ❍ Diverticulosis
- ❍ Diverticulitis
- ❍ Esophageal Cancer
- ❍ Esophagitis
- ❍ Fatty Liver
- ❍ Gallstones/Gallbladder Disease
- ❍ Gastritis
- ❍ GERD/Heartburn
- ❍ H-Pylori
- ❍ Hemorrhoids
- ❍ Hepatitis A
- ❍ Hepatitis B
- ❍ Hepatitis C
- ❍ Hepatitis, Other
- ❍ Hiatal Hernia
- ❍ Irritable Bowel Syndrome
- ❍ Liver Cancer
- ❍ Obstruction of Colon or Intestine
- ❍ Other Liver Disease
- ❍ Other Rectal Disease
- ❍ Pancreatic Cancer
- ❍ Pancreatitis
- ❍ Serious Injury to Abdomen
- ❍ Stomach Cancer
- ❍ Other _____

Other Medical Illnesses ❍ **None**

- ❍ Abnormal Heart Rhythm
- ❍ AIDS or HIV Infection
- ❍ Angina
- ❍ Anxiety or Depression
- ❍ Arthritis, Osteo
- ❍ Arthritis, Rheumatoid
- ❍ Asthma
- ❍ Bladder Disease
- ❍ Blood Clotting Disorders
- ❍ Blood Clots
- ❍ Breast Cancer
- ❍ Bronchitis
- ❍ Coronary Artery Disease
- ❍ Diabetes, Insulin Dep.
- ❍ Diabetes, Non-Insulin
- ❍ Disease of the Ovaries
- ❍ Emphysema
- ❍ Endometriosis
- ❍ Glaucoma
- ❍ Gynecological Cancer
- ❍ Heart Attack
- ❍ Heart Failure
- ❍ Heart Murmurs
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Hyperthyroidism
- ❍ Hypothyroidism
- ❍ Kidney Failure
- ❍ Kidney Stones
- ❍ Leukemia
- ❍ Lung Cancer
- ❍ Lymphoma
- ❍ Obesity
- ❍ Other Blood Disorders
- ❍ Other Cancer
- ❍ Pneumonia
- ❍ Prostate Disease
- ❍ Prostate Cancer
- ❍ Recurrent Urine/Bladder Infect.
- ❍ Rheumatic Fever
- ❍ Seizures
- ❍ Sleep Apnea
- ❍ Stroke
- ❍ Tuberculosis
- ❍ Other _____

Obstetric History (Women Only)

Have you ever been pregnant? ❍ Yes ❍ No IF YES, how many times have you been pregnant? _____
Are you pregnant now? ❍ Yes ❍ No
Do you use any type of birth control? ❍ Yes ❍ No ❍ Does Not Apply (i.e. post-menopausal, hysterectomy, tubal ligation, etc.) IF YES, what type? _____
Do you have periods (menses)? ❍ Yes ❍ No IF YES, when did your last period end? _____
Are your periods regular? ❍ Yes ❍ No Average number of days: _____
Are your periods normal? ❍ Yes ❍ No Are your periods heavy? ❍ Yes ❍ No

Previous Surgeries ❍ **None**

- ❍ Appendectomy
- ❍ Back Surgery
- ❍ Bladder Surgery
- ❍ Cancer Surgery
- ❍ Capsule Endoscopy
- ❍ C-Section
- ❍ Colonoscopy Date: _____
- ❍ Colon Surgery
- ❍ ERCP
- ❍ Eye or Ear Surgery
- ❍ Heart Bypass Surgery
- ❍ Hysterectomy
- ❍ Other Stomach Surgery
- ❍ Other Surgeries to the Bone or Spine
- ❍ Pacemaker/Defibrillator Placement
- ❍ Prostate Surgery
- ❍ Removal of Gallbladder
- ❍ Removal of Hemorrhoids
- ❍ Removal of Kidney Stone
- ❍ Removal of Ovaries
- ❍ Removal of Tonsils and Adenoids
- ❍ Repair of Hiatal Hernia
- ❍ Repair of Other Hernia
- ❍ Replacement of Heart Valve(s)
- ❍ Replacement of Joints _____
- ❍ Surgery for Adhesions
- ❍ Surgery for Bowel Obstruction
- ❍ Surgery of the Breast
- ❍ Surgery of the Pancreas or Liver
- ❍ Surgery to the Esophagus
- ❍ Surgery to the Kidney
- ❍ Surgery to the Lung
- ❍ Surgery to Stop Bleeding
- ❍ Surgery to the Thyroid Gland
- ❍ Tubal Ligation
- ❍ Ulcer Surgery
- ❍ Upper Endoscopy (EGD)
- ❍ Other Surgeries _____

Family

What is your marital status? ❍ Single ❍ Married ❍ Widowed ❍ Divorced

Do you have children? ❍ Yes ❍ No IF YES, how many children? _____

Occupation

Are you currently employed? ❍ Yes ❍ No IF NO, are you retired? ❍ Yes ❍ No

What is your current or most recent occupation? _____

Race: ❍ White ❍ African American ❍ Asian ❍ Hispanic ❍ Other ❍ Prefer not to answer

Preferred Language: _____

Habits

Tobacco Use

Do you currently smoke or regularly use other tobacco products? ❍ Yes ❍ No IF YES, How much do you use? _____ packs each day or _____

How long have you used tobacco products? _____years. IF NO, have you smoked or regularly used tobacco products in the past? ❍ Yes ❍ No

Alcohol

Do you currently drink alcoholic beverages? ❍ Yes ❍ No IF YES, how much do you drink? _____

How often? ❍ Every day or _____ days each ❍ week ❍ month

How long have you used alcohol? _____ years

If you answered no to the question above, have you used alcohol regularly in the past? ❍ Yes ❍ No

If yes, how much _____

Other Personal Exposures

Have you ever used drugs for non-medical reasons? ❍ Yes ❍ No

Have you ever used needles to inject (IV or otherwise) non-prescribed drugs? ❍ Yes ❍ No

Have you ever received a blood transfusion? ❍ Yes ❍ No If Yes, when? _____

How many units (pints) have you received? _____

Have you ever been tested for HIV (AIDS virus)? ❍ Yes ❍ No If Yes, when? _____

Do you have any objections to being tested for HIV? ❍ Yes ❍ No

Have you ever had tattoos or body piercings? ❍ Yes ❍ No

Family History	Father	Mother	Child(ren)	M/F Sibling 1	M/F Sibling 2	M/F Sibling 3	M/F Sibling 4
Deceased	❍	❍	❍	❍	❍	❍	❍
Current Age	_____	_____	_____	_____	_____	_____	_____
Age at Death	_____	_____	_____	_____	_____	_____	_____
Breast Cancer	❍	❍	❍	❍	❍	❍	❍
Colon Cancer	❍	❍	❍	❍	❍	❍	❍
age at diagnosis	_____	_____	_____	_____	_____	_____	_____
Colon Polyps	❍	❍	❍	❍	❍	❍	❍
Crohn's Disease	❍	❍	❍	❍	❍	❍	❍
Esophageal Cancer	❍	❍	❍	❍	❍	❍	❍
Gallstones	❍	❍	❍	❍	❍	❍	❍
Gastric Cancer	❍	❍	❍	❍	❍	❍	❍
Heart Problems	❍	❍	❍	❍	❍	❍	❍
Liver Disease	❍	❍	❍	❍	❍	❍	❍
Pancreatic Cancer	❍	❍	❍	❍	❍	❍	❍
Skin Cancer	❍	❍	❍	❍	❍	❍	❍
Stomach Cancer	❍	❍	❍	❍	❍	❍	❍
Ulcerative Colitis	❍	❍	❍	❍	❍	❍	❍
Other	_____	_____	_____	_____	_____	_____	_____
	❍ None	❍ None	❍ None	❍ None	❍ None	❍ None	❍ None

Name: _____

Immunizations

❍ Hepatitis A ❍ Hepatitis B ❍ Pneumovax ❍ None

Current Medications

Please list all medications including any over-the-counter pain medications or herbal products used more than on occasion

	Drug	Dosage	Frequency
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____

Allergies

❍ None ❍ Demerol ❍ Penicillin ❍ Sulfa
❍ Aspirin ❍ Eggs ❍ Latex ❍ Propofal/Diprivan
❍ Versed ❍ Other _____

Review of Systems

Gastrointestinal

❍ None ❍ Change in Bowels Habits ❍ Incontinence of Stools ❍ Red Blood in Stool
❍ Abdominal Pain, Upper ❍ Constipation ❍ Jaundice ❍ Swallowing Trouble (Blockage)
❍ Abdominal Pain, Lower ❍ Diarrhea ❍ Loss of Appetite ❍ Swallowing Trouble (Pain)
❍ Abdominal Swelling ❍ Gas (belching) ❍ Nausea ❍ Vomiting
❍ Black Stools ❍ Gas (flatulence) ❍ Painful Bowel Movements ❍ Other _____
❍ Bloating ❍ Heartburn

Constitutional	Skin/Integumentary	Eyes	Ears
❍ None	❍ None	❍ None	❍ None
❍ Chills	❍ Eczema	❍ Double Vision	❍ Ringing in Ears
❍ Fatigue	❍ Itching	❍ Pain	❍ Hard of Hearing
❍ Fever	❍ Jaundice		
❍ Loss of Appetite			

Nose	Throat	Respiratory	Cardiovascular
❍ None	❍ None	❍ None	❍ None
❍ Post-Nasal Drip	❍ Hoarseness	❍ Cough	❍ Angina-Chest Pain
❍ Nose Bleeds	❍ Chronic Sore Throat	❍ Shortness of Breath	❍ Heart Murmur
	❍ Frequent Clearing of Throat		❍ Irregular Heart Beat
			❍ Peripheral Edema

Hematologic	Genitourinary	Musculoskeletal	Neurological
❍ None	❍ None	❍ None	❍ None
❍ Blood Transfusions	❍ Dark Urine	❍ Back Pain	❍ Dizziness
❍ Prolonged Bleeding	❍ Irregular Menstruation	❍ Joint Pain	❍ Memory Loss/Confusion

Psychiatric	Endocrine	Allergy/Immunologic	
❍ None	❍ None	❍ None	❍ HIV Exposure
❍ Anxiety/Depression	❍ Weight Loss	❍ Allergies (Environmental)	❍ Immune Deficiency
❍ Suicidal Thoughts	❍ Weight Gain		