

# Digestive Health Specialists, PA

## Patient History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female  
Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_ Date \_\_\_\_\_

Please complete both pages of this form. Check off any conditions you may have now, or have experienced in the past.

**\*\*Please check None within each section that does not apply to you.\*\***

### Allergies:

- None  Aspirin  Demerol  Morphine  Penicillin  Sulfa  Valium  Versed  Other \_\_\_\_\_
- None

### Past or Present Medical Problems:

- None of these  Skin Cancer  Blood Transfusions  Defibrillator  Colon Polyps
- Breast Cancer  Other Cancer  Kidney Disease  Diabetes  Pancreatitis
- Colon Cancer  Asthma  Kidney Stones  Stroke  Reflux
- Liver Cancer  Chronic Lung Disease  Heart Attack  Gallstones  Ulcer
- Lung Cancer  Emphysema  High Blood Pressure  Hepatitis  Malignant Hyperthermia
- Prostate Cancer  Anemia  Pacemaker  Liver Disease  Other \_\_\_\_\_

### Surgeries/Hospitalizations/Procedures:

- None of these  Heart Valve  ERCP  Joint Replacement  Prostate
- Appendectomy  Colon Resection  Gallbladder Surgery  Liver Biopsy  Upper Endoscopy
- C-Section  Colonoscopy  Hiatal Hernia  Mastectomy  Other: \_\_\_\_\_
- Cardiac Surgery  Colostomy  Hysterectomy  Obesity Surgery

### Social History Marital Status:

- Single  Separated  Married
- Divorced  Widowed

### Social History Recreational/Street Drugs:

- I have never used street drugs  I am currently using street drugs
- I have used street drugs in the past  I have been treated for substance abuse

### Social History Alcohol:

- Never  More than 2 days per week
- Rarely  2 days per week or less
- Daily  I quit using alcohol

### Social History Tobacco:

- I use tobacco products  I have never used tobacco
- I quit using tobacco products

## Review of Systems

### Stomach and Intestinal:

- No Problems  Constipation  Heartburn  Milk Intolerance  Ulcerative Colitis
- Abdominal Pain  Crohn's Disease  Hemorrhoids  Soiling  Other: \_\_\_\_\_
- Blood in Stool  Diarrhea  Irritable Bowel Disease  Trouble Swallowing

### Reproductive Organs:

- No Problems  Other: \_\_\_\_\_
- Frequent Urinary Infections  **Male**
- Change in Urinary Frequency  Testicle Problems
- Sexually Transmitted Disease  **Female**
- Blood in Urine  Heavy Periods
- Sexual Difficulty  Breast Lumps

### Skin:

- No Skin Problems  Psoriasis
- Jaundice  Chronic Rash
- Nodules  Skin Cancer
- Overall Itching  Other: \_\_\_\_\_

### Heart and Blood Vessels:

- No Heart problems  Shortness of Breath
- Angina/Chest Pain with Activity  Swelling in the Legs
- Irregular Heart Beat  Other: \_\_\_\_\_
- Pain in Legs when Walking

### Brain and Nervous System:

- No Problems  Weakness in Arms
- Chronic Numbness/tingling  Weakness in Legs
- Seizures  Other: \_\_\_\_\_
- Stroke or Paralysis

**Hormone and Glands:**

- No Problems
- Diabetes Taking Insulin
- Diabetes Taking Oral Medication

- Thyroid
- Other: \_\_\_\_\_

**Body Health**

- No Problems
- Fatigue
- Fever
- Night Sweats
- Poor Appetite

- Weight Gain
- Weight Loss
- Weight Stable
- Other: \_\_\_\_\_

**Mental Health:**

- No Mental Health Problems
- Abnormal Sleep
- Bipolar Disorder
- Chronic Anxiety

- Depression
- Memory Loss/Confusion
- Other: \_\_\_\_\_

**Eyes:**

- No Eye Problems
- Cataracts
- Change in Vision
- Glasses / Contacts

- Glaucoma
- Other: \_\_\_\_\_

**Blood and Tissue:**

- No Problems
- Bleeding Doesn't Stop Easily
- Enlarged Glands

- Frequent Bruising
- Other: \_\_\_\_\_

**Ears, Nose and Throat:**

- No Problems
- Bleeding Gums
- Chronic Sinus
- Hearing Loss
- Hoarseness

- Mouth Sores
- Nose Bleeds
- Ringing in Ear
- Other: \_\_\_\_\_

**Bones, Muscles and Joints:**

- No Bone or Joint Problems
- Back Pain
- Disc Problem

- Sciatica
- Swollen Joints
- Other: \_\_\_\_\_

**Breathing:**

- No Breathing Problems
- Chronic Cough
- Cough up Blood

- TB
- Positive TB Test
- Other: \_\_\_\_\_

**Family History:**

- No Family History of Colon Cancer
- No Family History of Polyps
- Adopted (Don't Know Family History)

**Family History: Please place a check mark by all that apply**

	Father	Mother	Brother	Sister	Grandfather	Grandmother
Deceased						
Healthy						
Alcoholism						
Colitis (Colon Inflammation)						
Colon Cancer						
Age at Diagnosis						
Colon Polyps						
Crohn's Disease						
Liver Disease						
Stomach Cancer						
Tendency of Bleeding						
Ulcer Disease						
Other Disease (write in)						

**Current Medications: Please list all prescriptions and over the counter medications you are currently taking.**

Name	Strength	Frequency	Name	Strength	Frequency

Current Pharmacy Name and Location \_\_\_\_\_

Continue on back if needed