

Digestive HealthCare Center, P.A.

(908) 218-9222 Fax (908) 218-9818

Medical and Family History Form

Please fill in the squares for the appropriate health information

Name: _____

Today's Date: _____

Chart No.: _____

Date of Birth: _____

Reason for Visit: _____

Allergies

- None Codeine Erythromycin IV Contrast Morphine Penicillin Sulfa Versed
 Aspirin Demerol Iodine Latex Novocain Propofol Tape
 Other _____

Past or Present Medical Illnesses

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Atrial
Fibrillation | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Paralysis | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Parkinson's
Disease | <input type="checkbox"/> TB Skin Test
Positive |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Duodenal Ulcer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chronic Lung
Disease
(COPD) | <input type="checkbox"/> Fatty Liver | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Problems with
anesthesia | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Cirrhosis of
Liver | <input type="checkbox"/> Frequent Urinary
Tract Infections | <input type="checkbox"/> Irritable Bowel
Syndrome | <input type="checkbox"/> Reflux | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Attack - MI | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Congestive
Heart
Failure | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Skin Cancer | |
| <input type="checkbox"/> Other _____ | | | | |

Previous Surgeries/Hospitalizations/Procedures:

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Liver | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Breast | <input type="checkbox"/> EGD/Upper Endoscopy | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Obesity Surgery | <input type="checkbox"/> Transplant Surgery |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> ERCP | <input type="checkbox"/> Hysterectomy Partial | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Cardiac Surgery | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hysterectomy Total | <input type="checkbox"/> Prostate | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Colon Resection - Left | <input type="checkbox"/> Heart Bypass Surgery | <input type="checkbox"/> Joint Surgery/ Replacement | <input type="checkbox"/> Sigmoidoscopy | |
| <input type="checkbox"/> Colon Resection – Right | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Kidney | <input type="checkbox"/> Stomach | |
| <input type="checkbox"/> Other _____ | | | | |

Social History – Alcohol:

- | | | | |
|--------------------------------|--|---------------------------------|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> More than 2 days/week | <input type="checkbox"/> Rarely | <input type="checkbox"/> Less than 2 days/week |
| <input type="checkbox"/> Daily | <input type="checkbox"/> I quit using alcohol | | |

Social History – Tobacco:

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> I use tobacco products | <input type="checkbox"/> I quit using tobacco products | <input type="checkbox"/> I have never used tobacco products | | |
| <input type="checkbox"/> Cigarettes: | <input type="checkbox"/> 1 pack per day | <input type="checkbox"/> 1 ½ pack per day | <input type="checkbox"/> 2 packs per day | <input type="checkbox"/> Greater than 2 packs per day |
| <input type="checkbox"/> Cigars | <input type="checkbox"/> Smokeless tobacco | | | |

Social History Illicit Drug Use:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> I use illicit drugs | <input type="checkbox"/> I quit using illicit drugs | <input type="checkbox"/> I have never used illicit drugs | <input type="checkbox"/> Injection drug use |
|--|---|--|---|

Social History Occupation:

Patient Occupation _____ Veteran

Review of Systems (Current Symptoms)

Gastrointestinal:

- None Bloating Flatulence/gas Rectal bleeding Weight gain
- Abdominal Pain Change in Bowel Habits Heartburn Rectal urgency Weight loss
- Anal/rectal Pain Constipation Mucus in stool Reflux
- Belching Diarrhea Nausea Soiling stool/incontinence
- Black stools Difficulty swallowing Pain with bowel movement Vomiting
- Other _____

Urinary:

- None Pain with urination
- Blood in urine Change in urinary frequency
- Kidney stones Other _____

Skin:

- None Skin Rash
- Itching Suspicious lesions
- Jaundice Other _____

Cardiovascular:

- None Heart murmur as an adult Shortness of breath when lying flat Palpitations
- Chest pain with exertion/angina Shortness of breath with exertion
- Other _____

Neurological:

- None Numbness in extremities
- Dizziness Seizures
- Fainting spells Stroke/weakness
- Frequent headaches Tremors
- Memory Disturbance Other _____

Endocrine:

- None Heat intolerance
- Hair change/loss Other _____

Constitutional:

- None Loss of appetite
- Chills Night sweats
- Fever Other _____

Psychiatric:

- None Depression
- Anxiety/panic Other _____

