Gastroenterology Medical History

Name: ______________________ DOB: __________ Date: __________

Referred by: ______________________ Doctor last seen: __________

Current Complaints: *(Check any of the following that apply to you)*

Difficulty swallowing	____	Painful Swallowing	____	Changes in weight	____
Abdominal Pain	____	Blood in stool	____	Changes in appetite	____
Constipation	____	Diarrhea	____	Mucous in stool	____
Vomiting	____	Nausea	____	Heartburn	____
Regurgitation	____	Belching	____	Laxative use	____
Fever	____	Bloating	____	Hepatitis C	____
Maroon colored stool	____	Eating disorder	____	Liver enzyme abnormalities	____

Reason For Visit if Any Other: ______________________

____

Allergies to Medicine	Reaction

Present Medications:

Drug	For

Recent X-rays or Lab Tests:

Test	Result	Date

Surgery/Operations:

	Reason	Date	Hospital & Doctor

Non-Surgical Hospitalizations:

Illness/Injury	Date	Hospital & Doctor

Social History:

Occupation: __________

Habits: **Amount Daily**

Do you use tobacco? ☐ Yes ☐ No

_____ Packs per day _____# of years

Do you drink alcoholic beverages?

☐ Never ☐ Occasionally ☐ Daily

Do you use or have you used cocaine, marijuana or street drugs?

☐ Never ☐ Occasionally ☐ Daily

Coffee/Tea __________

Sleep __________

Exercise __________

Hobbies __________

Childhood Disease __________

Immunizations __________

Tetanus __________

Family Medical History:

	Living	Age(s)	If deceased, cause of death
Spouse			
Children			
Father			
Mother			
Brothers			
Sisters			

_____ Doctor's Initial

Patient Label placed here

WakeMed Faculty Physicians

Gastroenterology Medical History

PERSONAL AND FAMILY MEDICAL HISTORY

HAVE YOU OR YOUR FAMILY MEMBERS HAD ANY OF THE CONDITIONS LISTED BELOW?

(Please circle any number if "yes")

Self	Family	
1	2	Osteoarthritis/Degenerative Joint Disease
1	2	Inflammatory Arthritis (e.g. Rheumatoid, Lupus)
1	2	Gout
1	2	Multiple Fractures
1	2	Problems with Anesthesia
1	2	Heart Attack/Heart Disease
1	2	Chest Pain 1 2 Seizures/Epilepsy
1	2	Palpitations/Irregular Heartbeat
1	2	Murmur/Mitral Valve Prolapse
1	2	High Blood Pressure
1	2	Chronic Cough/Pneumonia/Bronchitis
1	2	Asthma
1	2	Lung Disease/Emphysema/Shortness of Breath
1	2	Tuberculosis
1	2	Diabetes ("Sugar")
1	2	Urinary Tract Infections/Urinary Troubles
1	2	Kidney Disease/Dialysis
1	2	Kidney Stones
1	2	Circulation Problems/Vascular Disease
1	2	Anemia/Bleeding/Clotting Disorders/Hemophilia
1	2	Blood Clot/Deep Vein Thrombosis
1	2	Skin Disease. Give Type ________________
1	2	Venereal Disease

Self	Family	
1	2	Migraine Headaches/Frequent Headaches
1	2	Depression/Anxiety/Bipolar/Schizophrenia
1	2	Attention Deficient Disorder
1	2	Sleep Disorders
1	2	Fibromyalgia/Myofascial Pain
1	2	Stroke
1	2	Fainting/Dizziness
1	2	Thyroid Troubles
1	2	Gallbladder disease
1	2	Stomach problems/Ulcers
1	2	Hepatitis ("Yellow Jaundice")/Liver Disease
1	2	Diverticulitis
1	2	Coughing Up Blood
1	2	Black or Bloody Stools
1	2	Crohn's/Ulcerative Colitis
1	2	Weight Loss (Unexplained; not diet related)
1	2	Unexplained Fever
1	2	Serious or Recurrent Infections (Describe):

____

____

Self	Family		Whom
1	2	Breast Cancer	__________
1	2	Colon Cancer	__________
		Age of Onset __________	
1	2	Colon Polyps	__________
1	2	Endometrial, Uterine or Cervical Cancer	__________
1	2	Esophagus/Throat Cancer	__________
1	2	Stomach Cancer	__________

X ____ x ________________

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

_____ Doctor's Initial

Patient Label placed here

WakeMed Faculty Physicians

Gastroenterology Medical History

REVIEW OF SYMPTOMS

Please check the following if they apply to you:

	Yes	No
General:	______	______
Anorexia (lack of appetite)	______	______
Fatigue	______	______
Fever/Chills	______	______
Weight Loss or Gain	______	______
Night Sweats	______	______
Skin:		
Pruritis	______	______
Rash	______	______
HEENT:		
Acute Vision Changes	______	______
Earache	______	______
Sore Throat	______	______
Burning Sensation of Tongue	______	______
Neck:		
Mass	______	______
Swollen Glands	______	______
Respiratory:		
Asthma	______	______
Shortness of Breath	______	______
Bronchitis	______	______
Cough	______	______
Dyspnea	______	______
Cardiovascular:		
Chest Pain	______	______
Irregular Heartbeat	______	______
Pacemaker	______	______
Ankle Swelling	______	______
Heart Murmur	______	______
Hematologic:		
Easy bleeding / bruising	______	______
Blood Clot	______	______
Swollen Lymph Nodes	______	______
Anemia	______	______

	Yes	No
Gastrointestinal:		
Difficult or painful swallowing	______	______
Rectal Bleeding	______	______
Pain during bowel movement	______	______
Bloating/gas problem	______	______
Fecal incontinence	______	______
Yellow Eyes	______	______
Musculoskeletal:		
Back Pain	______	______
Joint Pain	______	______
Joint Swelling	______	______
Neurological:		
Dizziness	______	______
Headaches	______	______
Seizures	______	______
Loss of Balance	______	______
Psychiatric:		
Anxiety	______	______
Changes in Sleep Pattern	______	______
Depression	______	______
Hearing Voices	______	______
Endocrine:		
Appetite Changes	______	______
Thyroid Problems	______	______
Genitourinary:		
Pain on urination	______	______
Increased Urinary Frequency	______	______
Blood in Your Urine	______	______
Smelling Urine	______	______
Vaginal or Penile discharge	______	______
Coca-cola Colored Urine	______	______

______ Doctor's Initial

Patient Label placed here