COMPREHENSIVE GASTROINTESTINAL HEALTH
Health History Form

NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____ REFERRED BY: _____

HEIGHT: _____ WEIGHT: _____ PRIMARY CARE DOCTOR: _____

PHARMACY (name, location, phone/fax number): _____

GENDER IDENTITY

☐ Female ☐ Male ☐ Non-binary ☐ Other ☐ Trans (male to female) ☐ Trans (female to male)

SEX ASSIGNED AT BIRTH

☐ Female ☐ Male ☐ Uncertain

ALLERGIES

☐ NONE ☐ Codeine ☐ Iodine dye ☐ Morphine ☐ Propofol ☐ Surgical tape
☐ Aspirin ☐ Demerol ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Versed

Other: _____

Any prior difficulties with sedation or anesthesia (nausea/vomiting, high tolerance, other)? ☐ Yes ☐ No

REASON FOR YOUR VISIT TO THE OFFICE

☐ Heartburn
☐ Excessive belching
☐ Upper abdominal pain
☐ Diarrhea
☐ Rectal bleeding
☐ Decreased appetite
☐ Screening colonoscopy
☐ Difficulty swallowing
☐ Chest pain
☐ Lower abdominal pain
☐ Constipation
☐ Black stools
☐ Weight loss
☐ Personal history of colon polyps/cancer
☐ Painful swallowing
☐ Nausea
☐ Bloating
☐ Narrowed stools
☐ Hemoccult + stools
☐ Abnormal liver tests
☐ Family history of colon polyps/cancer
☐ Regurgitation
☐ Vomiting
☐ Gas/flatulence
☐ Rectal pain/itch
☐ Anemia
☐ Jaundice
☐ Abnormal ultrasound or CAT scan

Other: _____

Have you had any of the following done to evaluate for the cause of your symptoms?

☐ Laboratory tests or blood work
☐ Radiology imaging (x-rays, ultrasounds, CAT scans, MRIs, barium studies)
☐ Endoscopies (upper GI scope/EGD, ERCP, colonoscopy)
☐ Emergency room visits

*** If possible, we would greatly appreciate it if you could please bring any of these relevant records with you or have them faxed to our office in advance of your visit 224.407.2255.*

What medications, supplements, or dietary interventions have you tried to treat your symptoms with (non-prescription and prescription)?

_____

_____

PAST MEDICAL ILLNESSES

Gastrointestinal

- ☐ Heartburn/GERD
- ☐ Hiatal hernia
- ☐ Gastritis
- ☐ H. pylori
- ☐ Ulcer
- ☐ Celiac disease
- ☐ Bowel obstruction
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Irritable bowel (IBS)
- ☐ Lactose intolerance
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Colon polyp
- ☐ Colon cancer
- ☐ Hemorrhoids
- ☐ Anal fissure
- ☐ Anal fistula
- ☐ Stool incontinence
- ☐ Abnormal liver tests
- ☐ Fatty liver
- ☐ Hepatitis
- ☐ Cirrhosis

Cardiovascular

- ☐ High blood pressure
- ☐ Atrial fibrillation
- ☐ High cholesterol
- ☐ Rhythm disorder
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Congestive heart failure

Pulmonary

- ☐ Sleep apnea
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Sarcoidosis
- ☐ Emphysema
- ☐ Lung cancer
- ☐ Pneumonia
- ☐ Pleurisy

Neuropsychiatric

- ☐ Stroke or TIA
- ☐ Migraines
- ☐ Chronic headaches
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Eating disorder
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Myasthenia gravis
- ☐ Dementia

Endocrine

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Thyroid nodule
- ☐ Hyperthyroidism
- ☐ Goiter
- ☐ Pituitary problem
- ☐ Thyroid cancer
- ☐ Adrenal problem

Genitourinary

- ☐ Kidney disease
- ☐ Urinary tract infections
- ☐ Ovarian cyst(s)
- ☐ Ovarian cancer
- ☐ Kidney stones
- ☐ Bladder incontinence
- ☐ Uterine fibroids
- ☐ Uterine cancer
- ☐ Kidney tumors/cysts
- ☐ Prostate hypertrophy
- ☐ Abnormal pap smears
- ☐ Cervical cancer
- ☐ Bladder cancer
- ☐ Prostate cancer
- ☐ Cone biopsy/LEEP
- ☐ Endometriosis

Breast

- ☐ Fibrocystic breast changes
- ☐ Benign breast biopsy
- ☐ Breast cancer
- ☐ Chemo/radiation/surgery

Musculoskeletal

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Osteopenia
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Chronic back pain
- ☐ Gout

Eyes, Ears, Nose, and Throat

- ☐ Glaucoma
- ☐ Allergic rhinitis
- ☐ Sinusitis
- ☐ Oral thrush

Dermatologic

- ☐ Eczema
- ☐ Raynaud's syndrome
- ☐ Psoriasis
- ☐ Basal cell skin cancer
- ☐ Vitiligo
- ☐ Squamous cell cancer
- ☐ Alopecia
- ☐ Melanoma

Hematologic

- ☐ Anemia
- ☐ Blood transfusion
- ☐ Blood clot
- ☐ Hemochromatosis

Additional health history:

☐ Any other malignant tumors/cancers not previously mentioned: _____

☐ Any communicable disease, such as hepatitis, HIV, or sexually transmitted disease? _____

☐ Any other hospitalizations or medical conditions not previously mentioned: _____

PREVIOUS SURGERIES AND PROCEDURES

☐ Gallbladder	☐ Appendix	☐ Groin hernia repair	☐ Abdomen hernia repair
☐ Adhesion surgery	☐ Colon resection	☐ Hemorrhoid surgery	☐ Anti-reflux surgery
☐ Weight loss surgery	☐ D & C	☐ Uterine ablation	☐ C-section
☐ Tubal ligation	☐ Total hysterectomy	☐ Partial hysterectomy	☐ Vasectomy
☐ Prostate surgery	☐ Back surgery	☐ Lumpectomy	☐ Mastectomy
☐ Stent/angioplasty	☐ Heart bypass surgery	☐ Heart valve surgery	☐ Pacemaker
☐ Defibrillator	☐ Carotid surgery	☐ Vascular surgery	☐ Vein stripping

☐ Any other surgeries not previously mentioned: _____

MEDICATIONS

Please include all prescription and non-prescription medications (especially anti-inflammatories like Advil, Motrin, and Aspirin), as well as all supplements.

Medication Name	Dose and Frequency

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Children (ages): _____

Occupation: _____

Do you have any tattoos? ☐ Yes ☐ No

Do you use tobacco currently? ☐ Yes ☐ No

Did you ever use tobacco products? ☐ Yes ☐ No

When did you quit? _____

Number of packs per day? _____

How many years? _____

Do you drink alcohol? ☐ Yes ☐ No

Number of cups per day of caffeinated beverages? _____

How many glasses do you drink per day? _____

How many glasses do you drink per week? _____

Have you ever had a problem with alcohol or drug use? _____

FAMILY HISTORY

☐ Colon polyps ☐ Helicobacter pylori ☐ Crohn's disease ☐ Hepatitis B
☐ Colon cancer ☐ Stomach cancer ☐ Ulcerative colitis ☐ Hepatitis C
☐ Uterine cancer ☐ Ovarian cancer ☐ Celiac disease ☐ Hemochromatosis

If yes, list family members (i.e. mother, grandmother, sister, aunt) and age at diagnosis if polyps or cancers:

REVIEW OF SYSTEMS

General

☐ Fatigue ☐ Weakness ☐ Fever ☐ Night sweats

Cardiovascular

☐ Chest pain ☐ Palpitations ☐ Shortness of breath with exertion
☐ Ankle swelling/edema ☐ Varicose veins

Respiratory

☐ Cough ☐ Coughing blood ☐ Shortness of breath ☐ Wheezing

Neurologic

☐ Headaches ☐ Dizziness ☐ Localized numbness ☐ Speech difficulty
☐ Memory loss

Endocrine

☐ Cold intolerance ☐ Heat intolerance ☐ Excessive thirst ☐ Excessive hunger
☐ Dry skin ☐ Abnormal skin pigment ☐ Abnormal body hair ☐ Brittle hair

Genitourinary

☐ Blood in urine ☐ Burning urination ☐ Urinary incontinence ☐ Frequent urination
☐ Frequent urination at night

Males: ☐ Slow urinary stream ☐ Difficulty initiating urination ☐ Penile discharge

Females: ☐ Abnormal periods ☐ Menopause ☐ Vaginal discharge

Breast

☐ Lump(s) ☐ Pain ☐ Nipple discharge ☐ Enlargement (males)

Bones/Joints/Muscles

☐ Pain ☐ Swelling ☐ Stiffness

Oropharyngeal

☐ Mouth sores ☐ Tongue sores ☐ Tooth/gum problems

Skin

☐ Itching ☐ Rash ☐ Scaling

Hematology

☐ Swollen jaw ☐ Bruising ☐ Bleeding problems

Patient's Signature **Date**