MICHAEL V. GREENWELL, M.D. • LASZLO J.K. MAKK, M.D.
KEVIN J. HEINE, M.D. • BRIAN M. DOBOZI, M.D.

GASTROENTEROLOGY • HEPATOLOGY • GASTROINTESTINAL ENDOSCOPY

MEDICAL HISTORY INFORMATION

Patient Name:_______________________________________ Today's Date:__________________

Family Physician:_________________________________ Date of Birth:__________________

Your family physician is referring you to us for further evaluation. What kind of problem are you having?____
____

Have you had any of the following?	Yes/No	Comments
High Blood Pressure	Yes ___ No ___	______________________________
Low Blood Pressure	Yes ___ No ___	______________________________
Stroke	Yes ___ No ___	______________________________
Heart Attack/Heart Disease/Murmur	Yes ___ No ___	______________________________
Angina/Chest Pain	Yes ___ No ___	______________________________
Allergies/Sinus Problems	Yes ___ No ___	______________________________
Asthma	Yes ___ No ___	______________________________
Emphysema/COPD	Yes ___ No ___	______________________________
Lung Disease, TB	Yes ___ No ___	______________________________
Arthritis	Yes ___ No ___	______________________________
Diabetes/Hypoglycemia	Yes ___ No ___	______________________________
Seizures	Yes ___ No ___	______________________________
Fainting	Yes ___ No ___	______________________________
Rheumatic Fever	Yes ___ No ___	______________________________
Liver Disease (Cirrhosis, Cysts, etc.)	Yes ___ No ___	______________________________
Hepatitis	Yes ___ No ___	______________________________
Mono	Yes ___ No ___	______________________________
Jaundice	Yes ___ No ___	______________________________
Gallbladder Problems (Stones)	Yes ___ No ___	______________________________
Thyroid Disease	Yes ___ No ___	______________________________
Kidney (Failure/Stones)	Yes ___ No ___	______________________________
Stomach problems (ulcer, indigestion reflux, hiatal hernia)	Yes ___ No ___	______________________________
Colon Problems (polyps, ulcers, diarrhea, diverticulitis, apastic colon)	Yes ___ No ___	______________________________
Depression, Anxiety, Stress	Yes ___ No ___	______________________________
Neurological Disorders	Yes ___ No ___	______________________________
Cancer (specify type)	Yes ___ No ___	______________________________
Glaucoma/Cataracts	Yes ___ No ___	______________________________
Anemia	Yes ___ No ___	______________________________

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Rectal Bleeding Yes ___ No ___ ________________________________
Vomiting Blood Yes ___ No ___ ________________________________
Motion Sickness Yes ___ No ___ ________________________________
Blood Transfusions Yes ___ No ___ ________________________________
Bleeding Problems Yes ___ No ___ ________________________________
Other: ____

____

Do you smoke? Yes ___ No ___ How much? ______________________
Alcohol use? Yes ___ No ___ How much? ______________________
Caffeine use? Yes ___ No ___ How much?______________________
Illegal drug use? Yes ___ No ___ How much? ______________________

Please List All Your Past Surgeries and their dates:

Type	Y/N	Date
Tonsils	Yes ___ No ___	______________
Appendix	Yes ___ No ___	______________
Eye/Cataracts	Yes ___ No ___	______________
Gallbladder	Yes ___ No ___	______________
Stomach	Yes ___ No ___	______________
Colon	Yes ___ No ___	______________
Kidney	Yes ___ No ___	______________
Thyroid	Yes ___ No ___	______________
Hernia	Yes ___ No ___	______________
Breast	Yes ___ No ___	______________
Uterus	Yes ___ No ___	______________
Ovaries	Yes ___ No ___	______________
Prostate	Yes ___ No ___	______________
Heart	Yes ___ No ___	______________
Lung	Yes ___ No ___	______________
Other:	Yes ___ No ___	______________
______________________________		______________
______________________________		______________
______________________________		______________
______________________________		______________

Please list All/Any allergies to medicines and their reactions:

Medicine: ______________________________ Reaction: ______________________________
Medicine: ______________________________ Reaction: ______________________________
Medicine: ______________________________ Reaction: ______________________________
Medicine: ______________________________ Reaction: ______________________________
Medicine: ______________________________ Reaction: ______________________________

Do you have an allergy to latex? Yes ___ No ___

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Family Medical History – Parents, Siblings, Children

Stomach:	Yes ___	No ___	Relation: __________	
Colon:	Yes ___	No ___	Relation: __________	
Liver:	Yes ___	No ___	Relation: __________	
Gallbladder:	Yes ___	No ___	Relation: __________	
Cancer:	Yes ___	No ___	Relation: __________	Site: __________________
	Yes ___	No ___	Relation: __________	Site: __________________
	Yes ___	No ___	Relation: __________	Site: __________________

Please List All Medications Currently Taken (Include Herbs and Vitamins)

Medication	Strength	How Often

CURRENT SYMPTOMS (Please circle all that apply)

Reflux, nausea, vomiting, problems swallowing, rectal bleeding, abdominal pain, black stools, heartburn, jaundice, weight loss, diarrhea, constipation, other: ____

____

FOR OFFICE USE ONLY:

Patient Name: ____ Account Number:__________________

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