

WOODHOLME GASTROENTEROLOGY ASSOCIATES, P.A.

MEDICAL & FAMILY HISTORY FORM

Name: _____ Today's Date: _____

Reason for Visit: _____

Allergies

- | | | | | | |
|----------------------------------|----------------------------------|--------------------------------------|--|---------------------------------|-------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Demerol | <input type="checkbox"/> IV Contrast | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | Other _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Eggs | <input type="checkbox"/> Latex | <input type="checkbox"/> Propofol/Diprivan | <input type="checkbox"/> Versed | _____ |

Past or Present Medical Illnesses/Problems

- | | | | | | |
|--|--|--|---|---|-------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Celiac Sprue | <input type="checkbox"/> Esophageal Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Cancer | Other _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Gallstones | <input type="checkbox"/> HIV | <input type="checkbox"/> Reflux | _____ |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Seizure Disorder | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Gynecologic Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sexually Transmitted Disease | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sleep Apnea | _____ |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Liver Cancer | <input type="checkbox"/> Thyroid Disease | _____ |
| <input type="checkbox"/> Barretts Esophagus | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Ulcer | _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Ulcerative Colitis | _____ |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis, Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Urinary Infections | _____ |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pancreatitis | | _____ |

Surgeries/Hospitalizations/Procedures

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Cardiac Surgery | <input type="checkbox"/> Endoscopy/EGD | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Prostate Surgery |
| <input type="checkbox"/> Appendix Removal | <input type="checkbox"/> Cholecystectomy / Gallbladder Surgery | <input type="checkbox"/> ERCP | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Sigmoidoscopy |
| <input type="checkbox"/> Bravo Capsule | <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Esophageal Manometry | <input type="checkbox"/> Joint Surgery Replacement | Other _____ |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Gastric Bypass /Obesity Surgery | <input type="checkbox"/> Liver Biopsy | _____ |
| <input type="checkbox"/> Capsule Endoscopy | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Heart Valve Replacement/Repair | <input type="checkbox"/> Mastectomy | _____ |

Social History Marital Status

- | | | |
|-----------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Separated | <input type="checkbox"/> Married |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed | <input type="checkbox"/> Other |

Number of Children

- 1 2 3 4 5 6+ none

Social History Exercise

- | | | | |
|--|---------------------------------|--|---|
| <input type="checkbox"/> I do not exercise | <input type="checkbox"/> I walk | <input type="checkbox"/> I jog | <input type="checkbox"/> I bike |
| <input type="checkbox"/> I swim | <input type="checkbox"/> I golf | <input type="checkbox"/> I do aerobics | <input type="checkbox"/> I lift weights |

Social History Alcohol

- Never Social Daily

Social History Tobacco

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

Social History Occupation

Patient Occupation _____ Veteran

Social History Hobbies

Patient Hobbies _____

Are You Currently Experiencing Problems in any of the Following Areas?

Gastrointestinal

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Bloating | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Pain w/ Bowel Movement |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Blood In Stool | <input type="checkbox"/> Gas | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Trouble Swallowing |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Milk Intolerance | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Constipation | <input type="checkbox"/> Incontinence to Stool | <input type="checkbox"/> Nausea | Other _____ |
| | | | | _____ |
| | | | | _____ |

Urinary

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Irregular Menstruation |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Sexual Difficulty |
| <input type="checkbox"/> Change in Urinary Frequency | Other _____ |
| <input type="checkbox"/> Difficulty with Urination | _____ |
| | _____ |

Skin

- | |
|----------------------------------|
| <input type="checkbox"/> None |
| <input type="checkbox"/> Itching |
| Other _____ |

Cardiovascular

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Angina/Chest Pressure with Activity | <input type="checkbox"/> Ankle Swelling | Other _____ |

Neurological

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Numbness | Other _____ |

Endocrine

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Hair Change |
| <input type="checkbox"/> Excessive Thirst or Urination | Other _____ |

Constitutional

- | | |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Night Sweats | Other _____ |

Psychiatric

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Abnormal Sleep | <input type="checkbox"/> Memory Loss/Confusion |
| <input type="checkbox"/> Anxiety | Other _____ |

