GastroCare of El Paso

MEDICAL & FAIMLY HISTORY FORM

TODAY'S DATE:_____/_____/_____

NAME:_____ **DATE OF BIRTh:**_____/_____/_____

Chief Complaint:_____

Referring Physician Name:_____

Medications — Please list all of your current prescription and non-prescription medications. (ex. vitamins and supplements)

Medication Name:	**Dosage:**

Allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Iodine ☐ Latex ☐ Others:_____

Description of allergir reaction:_____

Pharmacy Information

Pharmacy Name_____ Pharmacy Phone (_____)_____

Pharmacy Address_____ City/State_____ Zip_____

Past Medical History

☐ Anemia	☐ Colon Polyps	☐ Gastritis	☐ Irritable Bowel Syndrome	☐ Prostate Enlargement
☐ Arthritis	☐ Congestive Heart Failure	☐ Gerd (Reflux)	☐ Kidney Disease/Failure	☐ Psoriasis
☐ Asthma	☐ Constipation	☐ GI Bleeding	☐ Liver Disease	☐ Rheumatic Fever
☐ Atrial Fibrillation	☐ Copd	☐ Heart Attack	☐ Neurologic Disorders	☐ Sciatica
☐ Barett's Esophagus	☐ Coroeany Artery Disease	☐ Heart Murmur	☐ Osteoporosis	☐ Seizures
☐ Bleeding Disorder	☐ Crohn's Disease	☐ Hepatitis	☐ Ovarian Cyst	☐ Sleep Apnea
☐ Blood Transfusion	☐ Depression	☐ Hiatal Hernia	☐ Pancreatitis	☐ Stroke
☐ Cancer	☐ Diabetes	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Tb (Tuberculosis)
☐ Chronic Sinusitis	☐ Diverticulosis	☐ High Cholesterol	☐ Peptic Ulcer	☐ Thyroid Disorders
☐ Cirrhosis	☐ Fatty Liver	☐ HIV Or AIDS	☐ Phlebitis	☐ Ulcerative Colitis
☐ Colon Cancer	☐ Gallbladder Disease	☐ Irregular Heart Beat	☐ Pneumonia	☐ Valvular Heart Diease

Previous Hospitalizations

Reason:	**Date:**

Surgeries/Procedures

☐ Appendectomy	Date:_____	☐ Heart Bypass	Date:_____	☐ Radiation Therapy	Date:_____
☐ Barium Enema	Date:_____	☐ Heart Valve Replacement	Date:_____	☐ Sigmoidoscopy	Date:_____
☐ Breast Surgery	Date:_____	☐ Hemorrhoid Surgery	Date:_____	☐ Small Bowel Resection	Date:_____
☐ Capsule Endoscopy	Date:_____	☐ Hiatal Hernia Repair	Date:_____	☐ Stomach Surgey	Date:_____
☐ Cholecystectomy	Date:_____	☐ Hysterectomy	Date:_____	☐ Thyroid Surgery	Date:_____
☐ Colon Surgery	Date:_____	☐ Joint Replacement	Date:_____	☐ Tonsillectomy	Date:_____
☐ Colonoscopy	Date:_____	☐ Kidney Surgery	Date:_____	☐ TUbal Ligation	Date:_____
☐ Colostomy	Date:_____	☐ Liver Biopsy	Date:_____	☐ Ulcer Surgery	Date:_____
☐ C-Section	Date:_____	☐ MRI	Date:_____	☐ Ultrasound	Date:_____
☐ Ct Scan	Date:_____	☐ Obesity Surgery	Date:_____	☐ Upper GI Series X-Ray	Date:_____
☐ EGD	Date:_____	☐ Ovarian Surgery	Date:_____	☐ Uterine Surgery	Date:_____
☐ ERCP	Date:_____	☐ Pacemaker Placement	Date:_____	☐ None	Date:_____
☐ Gallbladder Surgery	Date:_____	☐ Prostate (TURP)	Date:_____	☐ Other:_____	Date:_____

MEDICAL & FAIMLY HISTORY FORM

GastroCare of El Paso

Healthy/Alive	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Deceased	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Colon Polyps	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Colon Cancer	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Gastriculcer Disease	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Liver Disease	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Crohn's Disease	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Ulcerative Colitis	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Stomach Cancer	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Diabetes Mellitus	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Heart Attack	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Breast Cancer	☐ Father	☐ Mother	☐ Brothers	☐ Sisters
Other Cancer	☐ Father	☐ Mother	☐ Brothers	☐ Sisters

Social History

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Occupation:_____ unemployed retired student

Smoking History:	☐ never	☐ yes	_____packs per day for_____years	Quit (how long)_____
Alcohol use:	☐ no	☐ yes	amount per day_____for_____years	
Drug Use:	☐ no	☐ yes	specify drugs and amounts:_____	
Exercise Habits:	☐ no	☐ yes	how much and how often:_____	
Do you have any tattoos?	☐ no	☐ yes		
Do you have any piercings?	☐ no	☐ yes		
Recent travel outside US:	☐ no	☐ yes	where:_____	
Caffeine use:	☐ no	☐ yes	details:_____	

Date of last Pneumovax:_____**Date of last flu shot:**_____

Review of Systems — check all that apply at the present time

General
☐ chills
☐ loss of appetite
☐ night sweats
☐ weight gain
☐ weight loss
☐ feeling tired or poorly

Eyes
☐ worsening of vision
☐ blurred vision
☐ vision distortion
☐ eye pain

Otolaryngeal Systems
☐ earache
☐ nasal discharge
☐ mouth sores
☐ bleeding gums
☐ hoarseness
☐ throat pain
☐ sinus pain

Cardiovascular
☐ chest pain/discomfort
☐ fast heart rate
☐ swelling of legs
☐ vericose veins

Gastrointestinal
☐ abdominal swelling/pain
☐ belching
☐ black stools
☐ red blood in bowel movement
☐ change in bowel movement
☐ frequency
☐ constipation
☐ diarrhea
☐ difficulty swallowing
☐ fatty food intolerance
☐ full after eating small
☐ gas/bloating
☐ heartburn
☐ hemorrhoids
☐ yellow skin or eyes
☐ nausea
☐ pain with swallowing
☐ decrease in appetite
☐ rectal pain
☐ regurgitation of food
☐ incontinence of stool
☐ vomiting
☐ vomiting blood

Musculoskeletal
☐ joint pain
☐ joint stiffness
☐ swollen joints
☐ low back pain
☐ muscle pain

Skin Symptoms
☐ pruritis (itching)
☐ skin lesions
☐ rashes

Neurologic
☐ numbness or tingling
☐ dizziness/lightheadedness
☐ vertigo
☐ headaches
☐ weakness in arms or legs
☐ blurred vision
☐ memory lapses or loss

Psychiatric
☐ anxiety
☐ depression
☐ panic attacks
☐ loss of sleep

Endocrine
☐ heat or cold intolerance
☐ excessive thirst or urination
☐ hot flashes

Hematolofig/Lymphatic
☐ easy bruising tendency
☐ swollen glands
☐ nosebleeds

Urinary
☐ pain or difficulty with urination
☐ frequent urination
☐ blood in urine
☐ incontinece of urine

Genitoreproductive-Female
☐ vaginal discharge
☐ heavy periods
date of last period:_____

Genitoreprocutive-Male
☐ discharge from penis
☐ testicular pain
☐ testicular lump