HISTORY FORM

***Estrella Gastroenterology***

**Name:** _____ **Date of birth** ____/_____/_____ **Today's Date:** ____/_____/_____

**Referring Physician:** _____**Phone Number**_____

**Reason for Visit:** _____

## PAST OR PRESENT MEDICAL CONDITIONS

❑ **None**

- ❑ Anemia
- ❑ Asthma
- ❑ Arthritis
- ❑ Eye problems
- ❑ Hearing problems
- ❑ Sleep apnea
- ❑ Blood transfusion(s)
- ❑ Fibromyalgia
- ❑ Rheumatoid Arthritis
- ❑ Blood clotting problems
- ❑ Dialysis
- ❑ Kidney disease
- ❑ Convulsions/Seizures
- ❑ Stroke
- ❑ Anxiety/Depression
- ❑ Bipolar/Schizophrenia
- ❑ Chronic pain
- ❑ Chronic headaches
- ❑ Colon cancer
- ❑ Ovarian cancer
- ❑ Lung cancer
- ❑ Breast cancer
- ❑ Prostate cancer
- ❑ Cervical/Uterine cancer
- ❑ Kidney cancer
- ❑ Thyroid cancer
- ❑ Skin cancer
- ❑ Thyroid disease
- ❑ Osteoporosis
- ❑ Diabetes
- ❑ High blood pressure
- ❑ COPD/Emphysema
- ❑ Heart attack
- ❑ Cardiac arrhythmia
- ❑ Heart stents
- ❑ Pace maker/Defibrillator

- ❑ Pancreatitis
- ❑ Celiac disease
- ❑ Crohn's disease
- ❑ Ulcerative colitis
- ❑ Gallstones
- ❑ Cirrhosis of liver
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Other liver disease
- ❑ Diverticulitis
- ❑ Diverticulosis
- ❑ Hemorrhoids
- ❑ Irritable bowel syndrome
- ❑ Acid reflux/Heart burn
- ❑ Anal fissure/fistula
- ❑ Ulcer disease
- ❑ Colon polyps

Other: _____

## PREVIOUS SURGERIES ▪ PROCEDURES ▪ HOSPITALIZATIONS Please indicate dates

❑ **None**

- ❑ Appendix removal
- ❑ Cardiac bypass
- ❑ Heart valve replacement
- ❑ Implanted defibrillator(ICD)
- ❑ Gastric bypass/Surgery
- ❑ Gall bladder removal
- ❑ Hysterectomy
- ❑ C-section
- ❑ Ovary removal
- ❑ Breast Surgery
- ❑ Joint surgery
- ❑ Prostate
- ❑ Colon resection
- ❑ Ostomy
- ❑ Sigmoidoscopy
- ❑ ERCP
- ❑ Capsule endoscopy
- ❑ Barium enema
- ❑ Upper GI series
- ❑ MRI of Abdomen
- ❑ CT of abdomen
- ❑ Ultra sound
- ❑ Upper endoscopy (EGD)
- ❑ Colonoscopy

Other: _____

## REVIEW OF SYSTEMS Please indicate if your are experiencing, or have experienced in the last six (6) months

❑ **None**

**Constitutional**
- ❑ Weight gain
- ❑ Weight loss
- ❑ Fever

**Ear Nose Mouth and Throat**
- ❑ Change in vision
- ❑ Dry eyes
- ❑ Bleeding gums
- ❑ Hoarseness

**Respiratory**
- ❑ Chronic cough
- ❑ Shortness of breath

**Cardiovascular**
- ❑ Irregular heart beat
- ❑ Palpitations
- ❑ Passing out
- ❑ Angina/chest pressure
- ❑ Ankle swelling

**Hematologic/Lymphatic**
- ❑ Prolonged bleeding
- ❑ Easy bruising
- ❑ Enlarged glands

**Integumentary**
- ❑ Itching
- ❑ Rashes

**Musculoskeletal**
- ❑ Back pain
- ❑ Joint pain
- ❑ Muscle pain

**Neurological**
- ❑ Seizures
- ❑ Headaches
- ❑ Stroke or paralysis

**Endocrine**
- ❑ Excessive thirst
- ❑ Cold intolerance

**Psychiatric**
- ❑ Anxiety
- ❑ Depression
- ❑ Attention deficit

**Genitourinary**
- ❑ Blood in urine
- ❑ Urinary incontinence
- ❑ Urinary infections

**Gastrointestinal**
- ❑ Milk intolerance
- ❑ Loss of appetite
- ❑ Painful swallowing
- ❑ Trouble swallowing
- ❑ Chocking on swallowing
- ❑ Acid taste
- ❑ Regurgitation of food
- ❑ Heart burn
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas bloating
- ❑ Belching
- ❑ Jaundice
- ❑ Nausea
- ❑ Vomiting
- ❑ Feeling full after meal
- ❑ Abdominal distension
- ❑ Blood in stool
- ❑ Black stool
- ❑ Incontinence of stool
- ❑ Rectal prolapse
- ❑ Change in bowel habits
- ❑ Pain with bowel movement
- ❑ Rectal pain

**NAME** _____

## ALLERGIES

❑ **None**

❑ Penicillin
❑ Aspirin
❑ Sulfa
❑ Tetracycline

❑ Gluten
❑ Eggs
❑ Latex
❑ Nuts

❑ Codeine
❑ Propofol/Diprivan
❑ Demerol
❑ IV Contrast or iodine

Other Allergies: _____

_____

## MEDICATIONS Include vitamins and supplements

❑ **None** ❑ **See my list** ❑ **I am on medication(s) but I don't remember their names**

| Medication's name | Strength | How Often | Medication's name | Strength | How Often |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## FAMILY HISTORY

❑ **None**

| | Which family member | | Which family member |
|---|---|---|---|
| Breast cancer | _____ | Colon polyps | _____ |
| Stomach cancer | _____ | Crohn's disease | _____ |
| Female organ cancer | _____ | Colitis | _____ |
| Colon cancer | _____ | Liver disease | _____ |
| Celiac disease | _____ | Cirrhosis | _____ |

Others _____

## SOCIAL HISTORY

**Alcohol Consumption** ❑ None ❑ Every day ❑ Every week ❑ Every month ❑ Alcoholic ❑ Recovering Alcoholic

**Tobacco** ❑ Never smoked ❑ Current every day smoker ❑ Current some day smoker ❑ Former smoker

**Recreational drug use** ❑ No drug use ❑ Recreational drug use ❑ Past IV drug use ❑ Current IV drug use

## OTHER PERTINENT MEDICAL INFORMATION

_____

_____ _____

**Signature** **Date**

_____ For office use _____



Wgt: _____ Hgt: _____ BP: _____ P: _____