



# PATIENT'S PERSONAL HISTORY

CONFIDENTIAL RECORD: INFORMATION CONTAINED ON THIS FORM WILL NOT BE RELEASED, EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.

APPOINTMENT DATE \_\_\_\_\_  DR. FOX  DR. MORRISSETTE  DR. BUCKLEY  CINDY TOWNSEND, N.P.

PATIENT NAME \_\_\_\_\_ REFERRING PHYSICIAN \_\_\_\_\_  
LAST FIRST MIDDLE

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ PRIMARY CARE PHYSICIAN \_\_\_\_\_

OCCUPATION \_\_\_\_\_  SINGLE  MARRIED  DIVORCED  WIDOWED

CHIEF COMPLAINT (REASON FOR VISIT) \_\_\_\_\_

HOW LONG HAVE YOU EXPERIENCED THESE SYMPTOMS? \_\_\_\_\_ HOW OFTEN DO YOU EXPERIENCE THESE SYMPTOMS? \_\_\_\_\_

HAVE YOU PREVIOUSLY BEEN TREATED BY ANOTHER GASTROENTEROLOGIST?  YES  NO

IF YES, BY WHOM? \_\_\_\_\_ WHEN? (YEAR) \_\_\_\_\_ WHERE? \_\_\_\_\_

## PAST MEDICAL HISTORY

PLEASE CHECK IF YOU HAVE HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

- ANEMIA
- ARTHRITIS
- ASTHMA
- BLOOD CLOTS
- CANCER (TYPE \_\_\_\_\_ )
- CIRRHOSIS OF THE LIVER
- COLITIS
- COLON POLYPS
- DEPRESSION / ANXIETY
- DIABETES
- DIVERTICULOSIS / DIVERTICULITIS
- ELEVATED CHOLESTEROL / TRIGLYCERIDES
- EMPHYSEMA
- HEART DISEASE / HEART ATTACK
- HEART MURMUR
- HEPATITIS (TYPE \_\_\_\_\_ )
- HIGH BLOOD PRESSURE (HYPERTENSION)
- IRRITABLE BOWEL SYNDROME (SPASTIC COLON)
- KIDNEY DISEASE
- KIDNEY STONES
- LIVER DISEASE (TYPE \_\_\_\_\_ )
- LUNG DISEASE (TYPE \_\_\_\_\_ )
- MITRAL VALVE PROLAPSE
- PANCREATITIS
- PSYCHIATRIC DISORDER (TYPE \_\_\_\_\_ )
- SEIZURE DISORDER
- STOMACH ULCERS / PEPTIC ULCER DISEASE
- STROKE
- THYROID DISEASE

## PAST SURGICAL HISTORY

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING PROCEDURES:

- DATE (YEAR)
- \_\_\_\_\_ APPENDECTOMY (APPENDIX REMOVED)
  - \_\_\_\_\_ BACK SURGERY
  - \_\_\_\_\_ COLON (LARGE INTESTINE) SURGERY
  - \_\_\_\_\_ EPISIOTOMY (STITCHES WITH CHILDBIRTH)
  - \_\_\_\_\_ EYE SURGERY
  - \_\_\_\_\_ GALLBLADDER REMOVED (CHOLECYSTECTOMY)
  - \_\_\_\_\_ HEART SURGERY (BYPASS OR VALVE REPLACEMENT)
  - \_\_\_\_\_ HEMORRHOID SURGERY
  - \_\_\_\_\_ HERNIA SURGERY
  - \_\_\_\_\_ HYSTERECTOMY (OVARIES REMOVED  YES  NO)
  - \_\_\_\_\_ JOINT SURGERY (TYPE \_\_\_\_\_ )
  - \_\_\_\_\_ PACEMAKER (CARDIAC) OR DEFIBRILLATOR PLACEMENT
  - \_\_\_\_\_ PROSTATE SURGERY
  - \_\_\_\_\_ STOMACH SURGERY
  - \_\_\_\_\_ TONSILLECTOMY (TONSILS REMOVED)
  - \_\_\_\_\_ OTHER SURGERY - LIST BELOW:  
 \_\_\_\_\_  
 \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_ DIAGNOSTIC TESTS:
  - \_\_\_\_\_ BARIUM ENEMA
  - \_\_\_\_\_ CT SCAN (ABDOMEN AND/OR PELVIS)
  - \_\_\_\_\_ COLONOSCOPY
  - \_\_\_\_\_ EGD (UPPER G.I. ENDOSCOPY)
  - \_\_\_\_\_ LIVER BIOPSY
  - \_\_\_\_\_ SIGMOIDOSCOPY OR PROCTO
  - \_\_\_\_\_ ULTRASOUND (ABDOMEN AND/OR PELVIS)
  - \_\_\_\_\_ OTHER RECENT DIAGNOSTIC TESTS - LIST BELOW:  
 \_\_\_\_\_  
 \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_

## SOCIAL / PERSONAL HISTORY

DO YOU SMOKE?  NO  YES IF YES, \_\_\_\_\_ #PACKS/DAY FOR \_\_\_\_\_ YEARS ( IF A PREVIOUS SMOKER, QUIT \_\_\_\_\_ YEARS AGO)

DO YOU CHEW OR DIP TOBACCO?  NO  YES

DO YOU DRINK ALCOHOL?  NO  YES IF YES,  OCCASIONALLY  MONTHLY  WEEKLY  DAILY (HOW MUCH PER DAY? \_\_\_\_\_ )

HAVE YOU EVER HAD A BLOOD TRANSFUSION?  NO  YES, WHEN (YEAR) \_\_\_\_\_

DO YOU HAVE ANY RISK FACTORS ASSOCIATED WITH HIV/HEPATITIS?  NO  YES

CHECK ANY THAT APPLY TO YOU:

BLOOD TRANSFUSION  TATTOO  BODY PIERCING  IV DRUG USE (PAST OR PRESENT)  INTRANASAL (SNORTING) COCAINE USE (PAST OR PRESENT)

KNOWN SEXUAL CONTACT WITH PERSON INFECTED WITH HIV OR HEPATITIS  HOMOSEXUAL MALE

PRESENT WEIGHT \_\_\_\_\_ LBS. HEIGHT \_\_\_\_\_ IF ANY RECENT WEIGHT LOSS OR WEIGHT GAIN, HOW MUCH? \_\_\_\_\_ LBS.

## FAMILY HISTORY

HAS ANY OF YOUR IMMEDIATE FAMILY (MOTHER, FATHER, BROTHER, SISTER, SON, DAUGHTER) HAD: \_\_\_\_\_  
RELATIONSHIP TO YOU \_\_\_\_\_

COLON OR RECTAL CANCER \_\_\_\_\_

CANCER (TYPE: \_\_\_\_\_ ) \_\_\_\_\_

COLON OR RECTAL POLYPS \_\_\_\_\_

COLITIS (ULCERATIVE COLITIS OR CROHN'S DISEASE) \_\_\_\_\_

STOMACH ULCER / PEPTIC ULCER DISEASE \_\_\_\_\_

LIVER DISEASE \_\_\_\_\_

PANCREATITIS \_\_\_\_\_

GALLBLADDER DISEASE / GALLSTONES \_\_\_\_\_

HIGH BLOOD PRESSURE (HYPERTENSION) \_\_\_\_\_

DIABETES \_\_\_\_\_

STROKE \_\_\_\_\_

HEART DISEASE \_\_\_\_\_

NUMBER OF CHILDREN:

DAUGHTER(S) \_\_\_\_\_ SON(S) \_\_\_\_\_

NUMBER OF SIBLINGS:

SISTER(S) \_\_\_\_\_ BROTHER(S) \_\_\_\_\_

MOTHER'S AGE, IF LIVING \_\_\_\_\_

IF DECEASED, AGE AT DEATH \_\_\_\_\_

CAUSE OF DEATH \_\_\_\_\_

FATHER'S AGE, IF LIVING \_\_\_\_\_

IF DECEASED, AGE AT DEATH \_\_\_\_\_

CAUSE OF DEATH \_\_\_\_\_

**ARE YOU ALLERGIC TO ANY MEDICATIONS?**  NO  YES

**IF YES, PLEASE LIST:** \_\_\_\_\_

## PRESENT MEDICATIONS

LIST ALL CURRENT MEDICATIONS INCLUDING OVER THE COUNTER PRODUCTS (SUCH AS VITAMINS, ASPIRIN, HERBS) YOU TAKE ON A DAILY BASIS:

NAME	DOSAGE	HOW OFTEN	NAME	DOSAGE	HOW OFTEN
1			7		
2			8		
3			9		
4			10		
5			11		
6			12		

## REVIEW OF SYMPTOMS

PLEASE CHECK IF YOU PRESENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS:

CONSTITUTIONAL:  FEVER  NIGHT SWEATS  UNINTENTIONAL WEIGHT LOSS  ENLARGED LYMPH NODES  FATIGUE  DIZZINESS  FAINTING

HEAD, EYES, EARS, NOSE & THROAT:  PERSISTENT HEADACHES  IMPAIRED HEARING  EARACHE  SORE THROAT  CHRONIC SINUS PROBLEMS

HOARSENESS  RECENT CHANGE IN VISION

RESPIRATORY:  SHORTNESS OF BREATH  WHEEZING  CHRONIC COUGH

CARDIOVASCULAR:  CHEST PAIN  HEART PALPITATIONS  FLUID RETENTION

GASTROINTESTINAL:  DECREASED APPETITE  NAUSEA  VOMITING  ABDOMINAL BLOATING  DIARRHEA  CONSTIPATION  ABDOMINAL PAIN

RECTAL PAIN  HEMORRHOIDS  RECTAL BLEEDING  BLOOD IN STOOL  BLACK, TAR-LIKE STOOLS  CHANGE IN BOWEL HABITS

TAKE LAXATIVES (REGULARLY)  TROUBLE WITH LEAKING OF STOOL  TROUBLE SWALLOWING  PAINFUL SWALLOWING  HEARTBURN

REGURGITATION OF FOOD OR LIQUID  EXCESSIVE BLEEDING  EXCESSIVE GAS

GENITOURINARY:  PAIN/BURNING WITH URINATION  DIFFICULTY HOLDING URINE  BLOOD IN URINE  AWAKEN AT NIGHT TO URINATE ( \_\_\_\_\_ TIMES A NIGHT)

WOMEN ONLY:  VAGINAL DISCHARGE DATE OF LAST MENSTRUAL PERIOD: \_\_\_\_\_  POST-MENOPAUSE  BREASTFEEDING  TUBAL LIGATION

MEN ONLY:  PROSTATE PROBLEMS  IMPOTENCE  BURNING OR DISCHARGE FROM PENIS  VASECTOMY

NEUROLOGICAL:  SEIZURES  NUMBNESS OR TINGLING  CONFUSION  WEAKNESS

PSYCHIATRIC:  DEPRESSION  ANXIETY  SUICIDAL THOUGHTS

ENDOCRINE:  HEAT OR COLD INTOLERANCE  EXCESSIVE THIRST OR URINATION

HEMATOLOGICAL:  ABNORMAL BLEEDING  ABNORMAL BRUISING  ANEMIA

MUSCULOSKELETAL:  JOINT PAIN  JOINT SWELLING  BACK PAIN  MUSCLE PAIN

SKIN:  SKIN RASH  SKIN ITCHING

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_