GASTROENTEROLOGY HISTORY

Date ______________________________

Name ______________________________ Birth Date ______________________________
Marital Status (S M D W)

Employer ______________________________ Occupation ______________________________

FAMILY HISTORY

Is your father living? ☐ Yes Age _____ ☐ No List cause of death & age ______________________________

Is your mother living? ☐ Yes Age _____ ☐ No List cause of death & age ______________________________

Number Brothers living _____ Number deceased _____ Cause(s) of death ______________________________

Number Sisters living _____ Number deceased _____ Cause(s) of death ______________________________

Number Children living _____ Ages ______________ Number deceased ______________________________

HAVE ANY BLOOD RELATIVES HAD:

1. Colon cancer or polyps? ☐ Yes ☐ No
2. Ulcerative colitis or Crohn's Disease? ☐ Yes ☐ No
3. Pancreatitis? ☐ Yes ☐ No
4. Cirrhosis or other liver disease? ☐ Yes ☐ No
5. Peptic Ulcer? ☐ Yes ☐ No
6. Gallbladder disease or gallstones? ☐ Yes ☐ No

PAST HISTORY

List surgeries you have had

1. ______________________________ Year _____
2. ______________________________ Year _____
3. ______________________________ Year _____

List other hospitalizations & reason

1. ______________________________ Year _____
2. ______________________________ Year _____
3. ______________________________ Year _____

LIST MEDICATIONS AND DOSAGES including over-the-counter prescriptions such as aspirin, laxatives or antacids

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

LIST MEDICATION ALLERGIES OR INTOLERANCES

1. ______________________ 2. ______________________ 3. ______________________

Do you exercise regularly? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How much daily? ______________________________

Do you use other tobacco products? ☐ Yes ☐ No ______________________________

Have you ever smoked? ☐ Yes ☐ No When did you stop? ______________________________

How much coffee do you drink? ______ cups/day Caffeine or Decaf? ______________________________

How many caffeinated soft drinks? ______ /day

Do you drink Alcoholic Beverages? ☐ Yes ☐ No

If yes, specify types and amounts per week ______________________________

Have you ever used other recreational drugs ☐ Yes ☐ No

Have you had the following tests in the past 5 years?

Test	Yes	No
Chest x-ray	☐ Yes	☐ No
Upper GI (stomach) x-ray	☐ Yes	☐ No
Barium Enema (colon) x-ray	☐ Yes	☐ No
CAT Scan of abdomen	☐ Yes	☐ No
Gallbladder x-ray or ultrasound	☐ Yes	☐ No
Blood count (BCB)	☐ Yes	☐ No
Other blood test	☐ Yes	☐ No
Sigmoidoscopy	☐ Yes	☐ No
Colonoscopy	☐ Yes	☐ No
EGD (gastroscopy)	☐ Yes	☐ No