

# THE DIGESTIVE HEALTH CLINIC, LLC

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## PERSONAL MEDICAL HISTORY

FILL OUT ALL THREE PAGES – DO NOT LEAVE BLANKS

PATIENT'S NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

Have we seen you before? (When) \_\_\_\_\_ Seen family member? (Name) \_\_\_\_\_  
When? \_\_\_\_\_

**HISTORY:** Briefly describe your symptoms or why you are being seen today:

When did the symptoms begin? \_\_\_\_\_

**PAST MEDICAL HISTORY:** Have you had any of the following problems?

Yes	No		Yes	No	
( )	( )	rheumatic fever	( )	( )	artificial joint
( )	( )	angina pectoris	( )	( )	vascular graft
( )	( )	heart valve replaced	( )	( )	emphysema
( )	( )	pacemaker/defibrillator	( )	( )	asthma
( )	( )	heart attack	( )	( )	diabetes
( )	( )	atrial fibrillation	( )	( )	glaucoma
( )	( )	high blood pressure	( )	( )	thyroid disorder
( )	( )	anemia	( )	( )	gout
( )	( )	kidney disease	( )	( )	cancer
( )	( )	kidney stone	( )	( )	liver disease, jaundice
( )	( )	ulcers, stomach or duodenum	( )	( )	hepatitis
( )	( )	arthritis	( )	( )	depression
( )	( )	seizure, epilepsy	( )	( )	high triglycerides/cholesterol
( )	( )	stroke	( )	( )	nervous breakdown

List any other significant **ILLNESS** (Other than the usual childhood): \_\_\_\_\_

List all **OPERATIONS** (type, year): \_\_\_\_\_

List all serious **INJURIES/ACCIDENTS** (type, year): \_\_\_\_\_

List all other **HOSPITALIZATIONS** (reason, year): \_\_\_\_\_

**CONFIDENTIAL RECORD:** Information here will not be released unless you have authorized us to do so.

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PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**MEDICATIONS:** List all medicines you are currently taking, including any over-the-counter medicines, birth control pills, aspirin, vitamins, etc. (Drug name; mg.; times/day):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** List all allergies to any medications (Name, type of reaction):

\_\_\_\_\_  
\_\_\_\_\_

List any other specific allergies (seafood, tape, iodine, etc.):

\_\_\_\_\_

**PERSONAL / HABITS:** Occupation \_\_\_\_\_ retired \_\_\_\_\_  
married \_\_\_\_\_ divorced \_\_\_\_\_ single \_\_\_\_\_ separated \_\_\_\_\_ widow \_\_\_\_\_

Yes No

( ) ( ) Do you use tobacco? (type, amount/day, ? years) \_\_\_\_\_

( ) ( ) Do you use alcohol? (type, amount/day, ? years) \_\_\_\_\_

( ) ( ) Women, do you think you might be pregnant? \_\_\_\_\_

List any other aspect of your lifestyle which might affect your health:

\_\_\_\_\_

**FAMILY HISTORY:** Check if any blood relative has had the following:

- |                                        |                         |                                    |
|----------------------------------------|-------------------------|------------------------------------|
| ( ) colon cancer                       | ( ) liver disease       | ( ) anemia                         |
| ( ) colon polyps                       | ( ) cirrhosis           | ( ) bleeding tendency              |
| ( ) Crohn's disease/ulcerative colitis | ( ) gall bladder stones | ( ) kidney disease                 |
| ( ) ulcers                             | ( ) pancreatitis        | ( ) cancer (what type, who?) _____ |
| ( ) neurologic diseases                |                         | _____                              |

List significant illnesses that family members have had:

	If Living			If Deceased	
	Sex	Age	Health	Age at Death	Cause
Father					
Mother					
Brother/Sisters (Circle Sex)					
	M   F				
	M   F				
	M   F				
	M   F				
	M   F				
Husband/Wife					
Sons/Daughters (Circle Sex)					
	M   F				
	M   F				
	M   F				
	M   F				

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**RECENT SYMPTOMS**

Yes ( ) No ( ) <b>GENERAL</b> feel tired, worn out had chills, fevers, sweats lost or gained weight weight now _____ normal weight _____	Yes ( ) No ( ) <b>GASTROINTESTINAL</b> difficulty swallowing red rectal bleeding black stools diarrhea constipation recent change in bowels abdominal pain nausea/vomiting changed eating habits indigestion, bloat, gas specific food intolerances drink milk? Amount _____
Yes ( ) No ( ) <b>SKIN</b> skin rashes or itching changes in hair or nails skin changed color	Yes ( ) No ( ) <b>MUSCULOSKELETAL</b> trouble with hip joints joint pain or stiffness difficulty walking back pain
Yes ( ) No ( ) <b>EYES</b> pain in your eyes blurry vision change in vision glaucoma halos around lights	Yes ( ) No ( ) <b>NERVOUS SYSTEM</b> frequent headaches memory loss tingling arms, legs poor coordination/balance dizzy, faint spells convulsion, seizure weakness in arm/leg
Yes ( ) No ( ) <b>EARS/NOSE/THROAT</b> trouble hearing lump in throat drainage back of throat ringing/buzzing in ears sore tongue or mouth	Yes ( ) No ( ) <b>PSYCHIATRIC</b> feel depressed nervous breakdown sleep disturbances
Yes ( ) No ( ) <b>RESPIRATORY</b> persistent cough difficulty breathing	Yes ( ) No ( ) <b>ENDOCRINE</b> weakness feel too hot, too cold
Yes ( ) No ( ) <b>CARDIOVASCULAR</b> pain, pressure in chest swelling in feet or ankles awoken short of breath irregular or rapid heart short breath with exertion sleep with head up	Yes ( ) No ( ) <b>HEMATOLOGIC/LYMPHATIC</b> do you have swollen glands do you bleed easily Have you had blood transfusions?
Yes ( ) No ( ) <b>GENITOURINARY</b> burning, painful urination frequent urination trouble passing urine passed blood in urine	Yes ( ) No ( ) <b>ALLERGY/IMMUNOLOGIC</b> hives hay fever
Yes ( ) No ( ) <b>WOMEN ONLY</b> menstrual periods abnormal lumps in breast passed menopause/change  BE SURE TO TELL US IF YOU ARE PREGNANT OR BECOME PREGNANT.	LIST ANY OTHER SYMPTOMS THAT YOU THINK MIGHT BE IMPORTANT: _____ _____ _____