

DIGESTIVE HEALTH CLINIC, LLC

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PERSONAL MEDICAL HISTORY

FILL OUT ALL THREE PAGES – DO NOT LEAVE BLANKS

FULL 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.

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

<p style="text-align: center;">CONSTITUTIONAL</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> had chills, fevers, sweats <input type="checkbox"/> <input type="checkbox"/> weight loss</p>	<p style="text-align: center;">GENITOURINARY</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> burning <input type="checkbox"/> <input type="checkbox"/> frequent urination <input type="checkbox"/> <input type="checkbox"/> passed blood in urine</p>
<p style="text-align: center;">EYES</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> change in vision</p>	<p style="text-align: center;">WOMEN ONLY</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> menstrual periods abnormal</p> <p style="text-align: center;">BE SURE TO TELL US IF YOU ARE PREGNANT OR BECOME PREGNANT.</p>
<p style="text-align: center;">EARS/NOSE/THROAT</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> lump in throat <input type="checkbox"/> <input type="checkbox"/> drainage back of throat</p>	<p style="text-align: center;">NERVOUS SYSTEM</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> frequent headaches <input type="checkbox"/> <input type="checkbox"/> loss of strength</p>
<p style="text-align: center;">RESPIRATORY</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> persistent cough <input type="checkbox"/> <input type="checkbox"/> shortness of breath</p>	<p style="text-align: center;">PSYCHIATRIC</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> anxiety <input type="checkbox"/> <input type="checkbox"/> depression</p>
<p style="text-align: center;">CARDIOVASCULAR</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> pain, pressure in chest <input type="checkbox"/> <input type="checkbox"/> swelling in feet or ankles <input type="checkbox"/> <input type="checkbox"/> irregular or rapid heart</p>	<p style="text-align: center;">SKIN</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> skin rashes <input type="checkbox"/> <input type="checkbox"/> itching</p>
<p style="text-align: center;">GASTROINTESTINAL</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> <input type="checkbox"/> red rectal bleeding <input type="checkbox"/> <input type="checkbox"/> black stools <input type="checkbox"/> <input type="checkbox"/> diarrhea <input type="checkbox"/> <input type="checkbox"/> constipation <input type="checkbox"/> <input type="checkbox"/> recent change in bowels <input type="checkbox"/> <input type="checkbox"/> abdominal pain <input type="checkbox"/> <input type="checkbox"/> nausea <input type="checkbox"/> <input type="checkbox"/> vomiting <input type="checkbox"/> <input type="checkbox"/> heartburn</p>	<p style="text-align: center;">MUSCULOSKELETAL</p> <p>Yes No <input type="checkbox"/> <input type="checkbox"/> joint pain or stiffness <input type="checkbox"/> <input type="checkbox"/> back pain</p>