

## **WESTSIDE GASTROENTEROLOGY ASSOCIATES** **HEALTH HISTORY FORM**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Referred by: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

1. Describe your current problem(s):

A. \_\_\_\_\_

B. \_\_\_\_\_

2. **History of Present Illness** (your current symptoms). Check all that apply.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heartburn                | <input type="checkbox"/> Hepatitis/type ____    | <input type="checkbox"/> Flatulence            |
| <input type="checkbox"/> Trouble Swallowing       | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Weight loss           |
| <input type="checkbox"/> Painful swallowing       | <input type="checkbox"/> Liver problems         | <input type="checkbox"/> Fever                 |
| <input type="checkbox"/> Nausea/Vomiting          | <input type="checkbox"/> Pancreas problems      | <input type="checkbox"/> Lack of appetite      |
| <input type="checkbox"/> Pain/Burning in stomach  | <input type="checkbox"/> Gallbladder problems   | <input type="checkbox"/> Family history polyps |
| <input type="checkbox"/> History of ulcers        | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Fam Hist colon cncr   |
| <input type="checkbox"/> Vomiting blood           | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Family History ulcers |
| <input type="checkbox"/> Bloody stools            | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Family Hist colitis   |
| <input type="checkbox"/> Anemia (low blood count) | <input type="checkbox"/> Bloating               | <input type="checkbox"/> Fam Hist gallstones   |

3. **Past History**

A. **Surgical** – Check all that apply. List year and any comments.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Appendectomy _____        | <input type="checkbox"/> Hemorrhoidectomy _____  | <input type="checkbox"/> Stomach surgery ____ |
| <input type="checkbox"/> Breast surgery _____      | <input type="checkbox"/> Hernia repair _____     | <input type="checkbox"/> Thyroid surgery ____ |
| <input type="checkbox"/> Colon surgery _____       | <input type="checkbox"/> Hysterectomy _____      | <input type="checkbox"/> Tonsillectomy _____  |
| <input type="checkbox"/> Gallbladder surgery _____ | <input type="checkbox"/> Ovaries removed _____   | Other _____                                   |
| <input type="checkbox"/> Heart _____               | <input type="checkbox"/> Joint replacement _____ |   |
| <input type="checkbox"/> Brain _____               | <input type="checkbox"/> Spine _____             |   |

B. **Medical History** – Check all that apply. List the year and any comments.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Hepatitis _____          | <input type="checkbox"/> Seizures _____    | <input type="checkbox"/> Enlarged prostate ____ |
| <input type="checkbox"/> Other liver disease ____ | <input type="checkbox"/> Cancer _____      | <input type="checkbox"/> Thyroid disorder ____  |
| <input type="checkbox"/> Lung disease _____       | <input type="checkbox"/> Arthritis _____   | <input type="checkbox"/> High cholesterol ____  |
| <input type="checkbox"/> Heart disease _____      | <input type="checkbox"/> Psychiatric _____ | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> High blood pressure ____ | <input type="checkbox"/> Diabetes _____    |   |
| <input type="checkbox"/> Stomach/intestine _____  | <input type="checkbox"/> Glaucoma _____    |   |

C. **Allergies**  Pcn  Sulfa  Codeine  Latex  Other \_\_\_\_\_

D. **Medications**

Name	Strength	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- E. **Do you take:**  aspirin or arthritis medications  
 blood thinners – Coumadin, Plavix  
 Herbal supplements

4. **Family History:** F=father M=mother B=brother S=sister D=daughter  
 S=son A=aunt U=uncle GP=grandparent

Colon cancer_____	Gallstones_____	Stroke_____
Stomach cancer_____	Heart disease_____	Tuberculosis_____
Colitis_____	High blood pressure_____	Ulcerative colitis_____
Colon polyps_____	Liver disease_____	Stomach ulcers_____
Crohn's_____	Mental disease_____	Other_____
Diabetes_____	Pancreatitis_____	

5. **Social History** (if yes, please indicate how much per day)  
 Smoke\_\_\_\_\_ (pk/day)  Drink coffee\_\_\_\_\_ (cups/day)  Drink milk\_\_ (glasses/day)  
 Drink alcohol\_\_\_\_\_ (oz/day)  Drink tea\_\_\_\_\_ (glasses/day)  
 Drink carbonated beverages\_\_\_\_\_

6. Review of Systems. Check all that apply

HEENT

- History of Nosebleeds
- Sinus/postnasal drip
- Ringing in ears
- Sore Throat
- Other\_\_\_\_\_

GYN

- Vaginal bleeding
- Vaginal discharge
- Lower abdominal pain
- Irreg vaginal bleeding
- Other\_\_\_\_\_

PSYCHOLOGICAL

- Inability to sleep
- Panic attacks
- Anxiety all the time
- Inability to think
- Other\_\_\_\_\_

PULMONARY

- Chronic cough
- Cough up blood
- Asthma/wheezing
- Short of breath
- Other\_\_\_\_\_

NEURO

- Dizziness
- Vertigo
- TIA
- Memory problem
- Other\_\_\_\_\_

DERMATOLOGIC

- Skin rash
- Hair loss
- Change in skin color
- Change in mole
- Itching
- Other\_\_\_\_\_

CARDIAC

- Chest pain
- Palpitations
- Swollen ankles
- Short of breath lying down
- Other\_\_\_\_\_

OPHTHALMOLOGIC

- Red eye
- Blurred vision
- Painful eye
- Blind spots
- Other\_\_\_\_\_

DENTAL

- Gum bleed
- Tooth pain
- Bad breath
- Sensitive teeth
- Loss of teeth
- Dentures/partials
- Other\_\_\_\_\_

GI

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Difficulty swallowing
- Other\_\_\_\_\_

ENDOCRINE

- Hot/Cold
- Excessive thirst
- Excessive urination
- Significant weight gain/loss
- Other\_\_\_\_\_

MUSCULOSKELETAL

- Joint swelling
- Joint pain
- Pain not relieved by rest
- Spine pain
- Other\_\_\_\_\_

GU

- Painful urination
- Blood in urine
- Urethral discharge
- Urinate frequently
- Difficulty starting stream
- Other \_\_\_\_\_

HEMATOLOGIC

- Tired
- Irregular bleeding
- Easy bruising
- Blood clots
- Other \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

**7. Additional information**

---



---



---



---



---

I have filled this form out to the best of my abilities as accurately as possible.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Reviewed by \_\_\_\_\_ Initials \_\_\_\_\_

Jasmine Jeffers, MD \_\_\_\_\_

Lisa Dillard, MD \_\_\_\_\_