

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**

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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\_\_\_\_\_