Patient History

Name: _____ Date of Birth _____

Please list all MD's you see currently and Gastroenterologists you have seen in the past

MD's **Name** **Address** **Phone Number**

1)_____

2)_____

3)_____

Previous Illnesses/Hospitalizations:

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

Medications, Vitamins:
Name / Dosage / Frequency:

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

Medication Allergies:

1)_____

2)_____

3)_____

4)_____

5)_____

Previous Surgeries: **Date:**

1) _____

2) _____

3) _____

4)_____

5) _____

6) _____

7) _____

8) _____

9) _____

10)_____

11)_____

12)_____

Smoking History: _____

Alcohol History: _____

Tattoos: _____

Intravenous Drug Use:_____

Body Piercing:_____

Family History:

	Mother	Father	Sibling	Sibling	Sibling	Grand Parents	Children	Other
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Peptic Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐
Colitis	☐	☐	☐	☐	☐	☐	☐	☐
Gallstones	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐