**WESTSIDE GASTROENTEROLOGY**
CONSULTANTS

# History Form

Patient Name ________________________________Date of Birth_________________Age______
Referring Dr /Primary if different_____________________Other doctors you see _______________
Do you have family members that are patients here? _____________________________________
What problem or health concern would you like the doctor to address today?
________________________________________________________________________________

**Past Medical History-** Please circle all that apply

| | | | | |
|---|---|---|---|---|
| Diabetes | Ulcers | Diverticulitis | Heartburn/GERD | Heart Attack |
| High Blood Pressure | Colon Polyps | Sleep Apnea | High Cholesterol | Stroke |
| Kidney Disease | Cancer ______________ type | | Liver Disease ___________ type | |
| Antibiotics prior to a procedure Y/N | | | Heart Valve Disease/Replacement | |

*Other Health Problems*:
________________________________________________________________________________
________________________________________________________________________________

**Past Surgical History**- Please list all surgeries and approximate dates
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**GI Tests**- list any reason and date of tests
Upper Intestine Scope ________________ Liver Biopsy _________________________
Colonoscopy _______________________ Radiology Tests ______________________

**Medication Allergies-Please also list the type of reaction with each allergy**
________________________________________________________________________________
________________________________________________________________________________

**Medications**- Please list current medication with dosage and frequency. It is important to include over the counter medications, vitamins, herbal supplements, aspirin, Coumadin, and Plavix. If more space is needed please use the back or bring your list from home.

______________________ ____________________ ____________________
______________________ ____________________ ____________________
______________________ ____________________ ____________________

**Family History**-Circle if yes leave Blank if 'none'

| | **Mother** | **Father** | **Sibling** | **Child** |
|---|---|---|---|---|
| Colon Cancer | Y | Y | Y | Y |
| Polyps | Y | Y | Y | Y |
| Crohns or Ulcerative Colitis | Y | Y | Y | Y |
| Celiac Dis or other intestinal Cancer List _________ | Y | Y | Y | Y |
| Liver Disease List ____________ | Y | Y | Y | Y |

**Social History**- Marital status ________
Spouse name ____________________
Number of children _______________
Occupation _____________________
Tobacco use Y/N ___pk/d for ___ yrs
Alcohol use Y/N ___ amt per day/wk/yr
Other Drug Use (List) ______________