HINSDALE GASTROENTEROLOGY ASSOCIATES
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MEDICAL HISTORY

Date_____

Name _____ Birthdate _____ Age _____

Address _____ City, State_____ Zip Code_____

Home Phone _____ Number you can be reached at during the day _____

List the main reason for your visit. _____

Who referred you? Dr. _____

Please give us the names (first and last) of the doctors you are seeing.

Dr. _____ Dr. _____

Dr. _____ Dr. _____

Please list **ALL** of your medical conditions:

_____ _____ _____

_____ _____ _____

Please list **ALL** Surgeries:

Reason:	Year:

Please list any medications you are currently taking (dose and frequency). Include vitamins, aspirin or over the counter medicines.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? Yes / No If yes, list medication and reaction _____

Are you allergic to latex ? Yes / No Are you allergic to IV contrast dye? Yes / No

Do you drink alcohol? Yes / No How many drinks per week? _____ Do you smoke? Yes / No

Height _____ft. _____in. Weight _____lbs

Family History: Please check any condition a blood relative has had.

	Y	N	RELATION/AGE		Y	N	RELATION/AGE
Colon Cancer				Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
Other Digestive System Cancers				Celiac Disease			
Polyps in the colon				Liver Disease			

REVIEW OF SYSTEMS

		YES	NO
GENERAL	Do you currently have a fever?		
EYES	Have you noticed recent changes in vision?		
	Do you have blurred vision?		
CARDIOVASCULAR	Do you have chest pain?		
	Do you have irregular heartbeats?		
	Do you have shortness of breath with exertion?		
RESPIRATORY	Do you have difficulty breathing?		
	Have you noticed any wheezing?		
GASTROINTESTINAL	Have you noticed a change in bowel habits?		
	Do you have constipation? Y /N Diarrhea Y / N		
	Do you have any nausea and/or vomiting?		
	Do you have jaundice?		
	Have you seen blood from the rectum? Volume: small medium large Frequency: daily weekly monthly		
	Have you passed black tarry stools recently?		
	Do you have difficulty or pain with swallowing?		
	Do you have acid reflux or heartburn more than twice a week?		
GENITOURINARY	Do you have discomfort when you urinate?		
	Do you have urgency to urinate?		
SKIN	Do you have a rash?		
	Do you have itching?		
NEUROLOGIC	Do you have numbness or tingling?		
	Do you have a history of seizures?		
MUSCULOSKELETAL	Do you have bone pain?		
	Do you have back pain?		
ENDOCRINE	Do you have trouble tolerating the heat?		
	Do you have trouble tolerating the cold?		
	Have you had significant weight loss in the last year? If yes, number of lbs. _____		
	Have you had significant weight gain in the last year? If yes, number of lbs. _____		
PSYCHIATRIC	Do you have anxiety ?		
	Do you have depression?		
HEME-LYMPH	Do you bleed easily?		
	Have you noticed lymph node enlargement or tenderness?		

Anything else you would like the doctor to know? _____