

PRINCETON GASTROENTEROLOGY ASSOCIATES

MEDICAL HISTORY

Please complete all 3 pages prior to your office visit.

NAME: _____

DATE: _____

revised **DATE:** _____ init.____

revised **DATE:** _____ init.____

A. Medical History

1. Hospitalizations and Surgery - List the year and the reason for hospitalization or the type of surgery performed.

_____	_____
_____	_____
_____	_____
_____	_____

2. Have you ever had any of the following (please circle):

- | | | |
|----------------------------|----------------------|-----------------|
| High Cholesterol | Diabetes | Rheumatic Fever |
| High Blood Pressure | Emphysema/Bronchitis | Kidney Disease |
| Artrial Fibrillation | Asthma | Cancer |
| Chest Pain Angina | Sleep Apnea | Arthritis |
| Arrhythmia | Colon Cancer/Polyps | Seizures |
| Asthma | Liver Disease | Lyme Disease |
| Heart Failure | Reflux | Depression |
| Stroke | Ulcers | Tumor |
| Recent Cardiac Stress Test | Anemia | Thyroid Disease |
| Angioplasty/Stent | Gallstones | |

OTHER: _____

3. Medications - please list all medications you are currently taking, with tablet size and dosage. Include over-the-counter medicines as well as those taken only as needed.

4. Allergies - include medicines and other substances to which you are allergic. Describe the type of reaction you have had. Are you allergic to Latex?

A. Family History

1. List your close relatives along with the following information:

	<u>Living/age</u>	<u>Deceased and Age @ death</u>	<u>Cause of death or Significant medical conditions</u>
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

2. Do any illnesses (such as those listed in question A-2) run in your family? Please specify relation (i.e., aunt, grandparent, etc.)

B. Social History

1. Your marital status _____ Your occupation _____
Spouse's occupation _____

2. Habits: Cigarettes? _____ How much and how long? _____
Alcohol? _____ Drinks per day or per week? _____
Caffeine? _____ Cups of coffee or tea per day? _____
Exercise? _____ Type? _____

REVIEW OF SYSTEMS

Do you currently have any of the following (please circle):

- 1. **General** a. weight loss b. weight gain c. fatigue d. fever e. chills f. appetite changes
g. change in sleep habits h. decreased exercise tolerance
- 2. **Skin** a. rash b. itchiness c. skin color change d. moles e. sores f. hives g. skin reactions
h. presence of scars i. tenderness j. swelling k. nipple discharge l. varicose veins
m. breast pain n. breast lumps
- 3. **Eyes** a. change in vision b. glasses c. eye pain d. itching e. redness f. infection g. glaucoma
h. discharge i. spots j. twitching k. light sensitivity l. double vision m. last eye exam _____
- 4. **Ears** a. loss of hearing b. ringing c. vertigo (spinning)
Nose d. decreased smell e. pain f. infection g. sinusitis h. post-nasal drip i. difficulty breathing
Mouth, throat j. sore tongue k. swollen glands l. bad breath

(continued)

- 5. **Respiratory** a. cough b. chest pain c. wheezing d. coughing blood e. change in sputum f. asthma
g. tuberculosis h. bronchitis i. recurrent infection j. pleurisy k. pneumonia l. shortness of breath
- 6. **Cardiac** a. heart trouble b. angina c. high blood pressure d. murmur e. palpitations
f. irregular heartbeat g. swelling of ankles h. coldness/numbness of extremities
- 7. **Genital/Urinary** a. blood in urine b. burning c. incontinence d. urgency e. flank pain f. dribbling
g. kidney stones h. sexual difficulties
female - i. menopause j. post-menopausal bleeding k. excessive bleeding l. vaginal discharge
m. pain with periods n. # of pregnancies _____
male - o. testicle pain p. erectile dysfunction q. testicular masses r. penile discharge
- 8. **Musculoskeletal** a. muscle cramps b. muscle pain c. weakness d. atrophy e. joint pain f. fracture
g. scoliosis h. back injury i. joint stiffness j. joint swelling k. spinal deformity l. limitation walking
- 9. **Heme/Lymph** a. anemia b. bleeding c. bruising d. cancer e. transfusions f. fatigue
g. low platelet count h. enlarged glands i. slow healing j. phlebitis
- 10. **Neurologic** a. headaches b. fainting c. seizures d. vertigo e. blindness f. double vision
g. paralysis h. dizziness i. tremors j. memory loss k. unsteadiness l. numbness m. tingling
n. stroke o. blackouts
- 11. **Endocrine** a. weight change b. diabetes c. excessive sweating d. hair change/loss e. goiter
f. adrenal problems g. thyroid disease h. increased appetite i. thirst j. hormone therapy
- 12. **Psychiatric** a. anxiety b. sleep disturbance c. depression d. nervousness e. suicidal thoughts
f. delusions g. hallucinations h. memory loss i. confusion j. tension k. history of psych. treatment
- 13. **Allergy/Immunology** a. hay fever b. itching c. multiple colds d. slow healer e. sneezing f. hives
g. medication allergies _____

If you have circled any of the above, please provide more details if necessary:

details (frequency, duration, severity, etc...)

What is the reason for your visit today? _____

What questions would you like answered today?
