

**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):**

- |                      |               |              |                     |
|----------------------|---------------|--------------|---------------------|
| Colon Cancer/Polyps  | Reflux        | Ulcers       | Gallstones          |
| Liver Disease        | Asthma        | Anemia       | Diabetes            |
| Rheumatic fever      | Heart Failure | Heart Attack | Chest Pain/Angina   |
| Emphysema/Bronchitis | Stroke        | Arrhythmia   | High Blood Pressure |
| Kidney Disease       | Arthritis     | Lyme Disease | Thyroid Disease     |
| Tumor or cancer      | Seizures      | Depression   | High Cholesterol    |

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>
<b>Mother</b>	_____	_____	_____
<b>Father</b>	_____	_____	_____
<b>Siblings</b>	_____	_____	_____
	_____	_____	_____
<b>Children</b>	_____	_____	_____
	_____	_____	_____

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)

