MEDICAL HISTORY

Welcome to **The Center for Advanced Therapeutic Endoscopy**. Please take time to complete this medical history form. You may use a separate sheet of paper to provide any additional information.

Name_____**Age**_____**Date**_____

Referring Physician:_____

Reason for Visit: In your own words, please describe your current illness. Include date of Onset, treatment, and tests that you have already had:

Current and Past Medical Problems: Please check each of the following that apply to you:

	Yes	NO	Explain
Heart Disease			
Hypertension			
Diabetes			
Lung Disease (e.g. Asthma, TB)			
Liver Disease (e.g. Hepatitis)			
Kidney Disease			
Arthritis			
Cancer			
Thyroid Disease			
Elevated Cholesterol			
OTHER			

_____M.D.
Physicians Signature

Past Operations and/or Hospitalizations: Please list any operations or hospitalizations and the approximate dates. List the most recent first.

Operation or Hospitalization	Date	Hospital

Allergies: Please list any medication or food allergies and describe the reaction that you experience.

Allergy	Reaction
Penicillin	☐ Yes ☐ No

Medications: Please list any medication you currently take. Include the dosage and how often you take each medication. Please also include vitamins or herbal substances you currently take.

Medication	Strength	Frequency
Do you take Blood Thinners (If yes, specify)		
Do you take aspirin or anti-inflammatory medicine?		

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Physicians Signature

Lifestyle:

Do you currently smoke: No Yes
If yes, how many packs per day?_____How many years?_____

Have you ever smoked in the past? No Yes
If yes, how many years____ Date you quit smoking_____

Do you regularly drink beverages that contain caffeine? No Yes
If yes, describe the type and amount of beverage you consume daily?_____

Do you regularly drink wine, beer, or other alcoholic beverages No Yes
If yes, describe the type and amount you consume_____

Did you ever drink regularly? No Yes
For how long?_____ Date you stopped_____

Do you use recreational drugs? No Yes
If yes, describe the type and frequency at which you use these drugs_____
Ever use drugs through the vein (IV) No Yes

Employment_____ Retired: No Yes

Family History (Diabetes, Cancer, Heart Trouble, Stroke, etc):				
Relation:	Age	Health Problems	Age of Death	Cause of Death
Spouse				
Child 1				
Child 2				
Child 3				
Child 4				

Symptoms: Indicate if you currently have (or recently have had) any of the following:

_____M.D.
Physicians Signature

Chills/Fever	Yes No	Feeling excessive cold or warm	Yes No
Night Sweats	Yes No	Weight Loss	Yes No
Easy Bruising	Yes No	Itching	Yes No
Flushing	Yes No	Change in skin complexion	Yes No
Change in Energy Level	Yes No		

Neurological:

Severe Headaches	Yes No	Uncontrolled Movement	Yes No
Vision Problems	Yes No	Slurred Speech	Yes No
Recent Dizziness	Yes No	Convulsions/Seizures	Yes No
Paralysis	Yes No	Recent Passing out	Yes No
Glasses	Yes No		

Respiratory:

Recent Hoarseness Yes No

Chronic Cough Yes No

Coughing up sputum – How much per day (teaspoon, tablespoon, etc Yes No

Shortness of Breath with Exertion -How far can you walk without stopping? _____Yes No

Asthma or wheezing (Daytime or Nighttime) Yes No

Allergies or hay fever Yes No

Cardiovascular:

Waking up at night short of breath Yes No

Sleeping on extra pillows to breathe easier Yes No

Swelling of feet Yes No

Irregular heart rate; Palpitations Yes No

Chest pain or chest pressure after eating or when upset Yes No

Pain in legs or calves when walking Yes No

_____M.D.
Physicians Signature

History of heart murmur Yes No

Gastrointestinal

Does any food give you trouble	Yes No	Trouble with Bloating	Yes No
Trouble with drinking milk	Yes No	Troubled with Heartburn	Yes No
Camping trip in the past 6 months	Yes No	Difficult or painful swallowing	Yes No
Farm Visits in past 6 months	Yes No	Trouble with belching	Yes No
Pets at home	Yes No	Discomfort in pit of stomach	Yes No
Staining underwear	Yes No	Easily Nauseated	Yes No
Intolerance to tight garments	Yes No	Vomiting	Yes No
Excessive Gas	Yes No	Vomiting Blood	Yes No
Ever had an Upper Endoscopy	Yes No	Can't Control Bowel Movement	Yes No
Ever had X-Rays of stomach/colon	Yes No	Ever had proto/colonoscopy	Yes No
Diarrhea/Loose Stools	Yes No	Ever had hepatitis	Yes No
Constipated more than twice/month	Yes No	Cola-colored urine	Yes No
Pain when moving bowels	Yes No	Elevation of blood tests related to pancreas or liver while having abdominal pain	Yes No
Bowel Movement black or bloody	Yes No	Blood on toilet paper	Yes No
Bleeding from Rectum	Yes No	Intestinal noise	Yes No

Genitourinary:

Frequently up at night to urinate	Yes No	Hesitancy with urination	Yes No
Urinate more than five-six times/day	Yes No	Brown, black or bloody urine	Yes No
Wet your pants or the bed	Yes No	Difficulty starting urine flow	Yes No
Burning or pain during urination	Yes No	Any Kidney stones	Yes No
Air or bubbles when urinating	Yes No		

_____M.D.

Physicians Signature

Women

Recent Vaginal discharge Yes No

Menstrual Irregularities Yes No

Discharge from nipple Yes No

Lump or pain in breast Yes No

Problems in sexual activity Yes No

Date of last menstrual cycle: _____

Date of last mammogram:_____

Date of last pap:_____

Men

Discharge from penis Yes No

Hernia Yes No

Prostate problems Yes No

Problems with sexual activity Yes No

Very weak/ slow urine stream Yes No

Swelling or lumps on testicles Yes No

Painful testicles Yes No

Homosexual activity Yes No

Muscle/Joints

Arthritis Yes No If yes, _____

Joint Pain Yes No If yes_____

Muscle aches or weakness Yes No If yes,_____

_____M.D.
Physicians Signature