Gastroenterology Clinic
Medical History Form Date:________________________________

Name:____ Age________________

Referring MD:

Name Address

History of Present Illnes:

Past Medical History
Diagnosis/Symptom Date(Year)

Past Surgical History_

Procedure ___________________________________

Date(Year)________________

Current Medication List

Drug Dose Date Started

Drug Allergies None Please Circle________________

Hives or Anaphylaxis

Hives or Anaphylaxis

Hives or Anaphylaxis

Hives or Anaphylaxis

Habits

1. Cigarettes	Y/N	____pack/day x ____years	DC ______year
2. Alcohol	Y/N	____drinks/day/wk x ____yrs	DC______year
3. IV Drug	Y/N	____ type______x_____yrs	DC______year
		____ type______x_____yrs	DC______year

Social History

1. Profession:______________________________Retired: Y/N, if Y When: ________

2. Country of Birth: ____

3. Time to U.S: ____

4. Marital Status: Married Divorced Widowed Single Engaged

Family History
(Draw family tree: Parents, siblings, children, age of death and medical problems)

Family History (cont): Circle Positive and list relationsip:

1. Colon Polyp
2. Peptic Ulcer
3. Gallstones
4. Pancreatitis
5. Inflammatory Bowel Disease
6. Liver Disease (Specify)
7. GI Cancer: Esphageal Gastric
   Pancreas Colon
   Liver Biliary
8. Breast Cancer
9. Uterine Cancer
10. Hypertension
11. Coronary Artery Disease
12. COPD
13. Diabetes mellitus
14. Other