ASHEVILLE GASTROENTEROLOGY ASSOCIATES
A Division of Digestive Health Partners, P.A.

PATIENT MEDICAL HISTORY FORM

NAME: _____ EMAIL ADDRESS: _____

ADDRESS: _____ FAMILY PHYSICIAN: _____

_____ REFFERING PHYSICIAN: _____

DATE OF BIRTH: _____ HOME PH#: _____ CELL#: _____

PHARMACY NAME: _____ PHARMACY LOCATION: _____

PROBLEM FOR WHICH YOU HAVE BEEN REFERRED: _____

_____

GENDER

☐ Male ☐ Female ☐ Other Height: Weight:

RACE

☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Hispanic/Latino
☐ American Indian/Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Mixed
☐ Other ☐ Unknown ☐ Patient declines to provide information

ETHNICITY

☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information

PREFERRED LANGUAGE

☐ English ☐ Other

PREVIOUS PROCEDURES/SURGERIES - Please write beside it the year in which you had the procedure

☐ None
☐ Appendix Removal
☐ C-Section
☐ Cardiac Defibrillator
☐ Cardiac Stent Placement
☐ Colon Resection
☐ Fundoplication - Nissen
☐ Gallbladder Removal
☐ Gastric Bypass Surgery
☐ Heart Bypass Graft
☐ Heart Valve Replacem
☐ Hiatal Hernia
☐ Hysterectomy
☐ Ileostomy
☐ Joint Surgery/Replacement Site_____ [R] [L]
☐ Liver Transplant
☐ Lysis of Adhesions
☐ Mastectomy [R] [L]
☐ Medication Pump
☐ Nephrectomy
☐ Pacemaker Placed
☐ PICC Line
☐ Port-a-Cath
☐ Prostate Surgery
☐ Shunt/Graft/Fistula
☐ Small Bowel Resection
☐ Tubal Ligation

Diagnostic Studies/Tests:

☐ Bravo Capsule
☐ Capsule Endoscopy
☐ Colonoscopy
☐ ERCP
☐ Esophageal Manometry
☐ Gastroscopy/Endoscopy (EGD)
☐ Liver Biopsy
☐ Sigmoidoscopy
☐ Other_____

History of

☐ History of difficult intubation or anesthesia reaction
☐ Problems with your last procedure?

IMMUNIZATIONS ☐ None ☐ Hepatitis A ☐ Hepatitis B ☐ Pneumovax ☐ Influenza ☐ Other_____

PAST OR PRESENT MEDICAL ILLNESSES ☐ None

☐ Abdominal Aortic Aneurysm
☐ Anemia
☐ Anxiety disorder
☐ Arthritis, Degenerative
☐ Arthritis, Rheumatoid
☐ Asthma
☐ Atrial Fibrillation
☐ Barrett's Esophagus
☐ Bleeding Disorder
☐ Blood Transfusions
☐ Breast Cancer
☐ Celiac Sprue
☐ Cirrhosis
☐ Colon Cancer
☐ Colon Polyps
☐ Coronary Artery Disease
☐ Crohn's Disease
☐ Depression
☐ Diabetes: insulin dependent
☐ Diabetes: non insulin depen.
☐ Diverticulitis
☐ Diverticulosis
☐ Emphysema or COPD
☐ Requiring Oxygen
☐ Endometriosis
☐ Esophageal Cancer
☐ Fatty Liver
☐ Gallstones
☐ Gastroesophageal Reflux
☐ Glaucoma
☐ Gynecologic Cancer
☐ Heart Attack
☐ Helicobacter Pylori
☐ Hemochromatosis
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ High Cholesterol/Lipids
☐ HIV/AIDS
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Irritable Bowel Syndrome
☐ Ischemic Colitis
☐ Kidney Dialysis
☐ Kidney Stones
☐ Leukemia
☐ Liver Cancer
☐ Liver Disease
☐ Lung Cancer
☐ Lymphoma
☐ Metal in Body
☐ Obesity
☐ Ovarian Cancer
☐ Pancreatitis
☐ Prostate Cancer
☐ Seizure Disorder
☐ Sleep Apnea
☐ Requiring C-PAP
☐ Stroke
☐ Tuberculosis
☐ Ulcer
☐ Ulcerative Colitis
☐ Other_____

MEDICATIONS, SUPPLEMENTS, HERBALS - Please be sure to include all BLOOD THINNING agents!!

	Drug Name	Strength	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

ALLERGIES ☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ None ☐ Sulfa ☐ Versed/Midazolam ☐ Eggs ☐ Penicillin ☐ Demerol ☐ Soy

☐ Aspirin ☐ Latex ☐ Propofol/Diprivan ☐ Codeine ☐ Fentanyl ☐ Other_____

Note what type of reaction you had to each med _____

FAMILY HISTORY	Father	Mother	Son/ Daughter	Brother/ Sister
No Knowledge of Family History ☐				
Colitis	☐	☐	☐	☐
Colon Cancer Age at diagnosis ____	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐

SOCIAL HISTORY

Military Veteran ☐ Yes

Tobacco ☐ Current everyday smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never smoker
☐ Smoker, current status unknown ☐ Unknown if ever smoked

Street/Illegal Drug Use ☐ Never ☐ I have used or experimented with street drugs

Alcohol ☐ None ☐ Rarely ☐ Daily
☐ More than 2 days/week ☐ Less than 2 days/week ☐ I quit using alcohol in _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced **OCCUPATION:** _____

SIGNATURE: _____ **TODAY'S DATE:** _____

Reviewed with: ☐ Patient ☐ Parent ☐ Guardian ☐ Not Present