# Scottsdale Gastroenterology Associates
# Health History Form

480-646-8444

PLEASE PRINT CLEARLY

| | | |
|---|---|---|
| Bring this form to your appointment: Date: | | Time: |
| Name: | Date of Birth: | M F |
| Referring doctor: | Primary care doctor: | |
| Preferred pharmacy location: | Pharmacy phone number: | |
| Reason for visit & problems, if any: | | |

MEDICATIONS: Please list all medications and/or bring a list with you. Include all over-the-counter medications.

| Medication Name | Strength of each dose | Number of doses at a time |
|---|---|---|
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| | | |
| | | |

ALLERGIES: Please list medication/food allergy and reaction.

☐ No known allergies  Do you have a latex allergy? Yes No

| | Medication | Reaction | | Medication | Reaction |
|---|---|---|---|---|---|
| 1 | | | 4 | | |
| 2 | | | 5 | | |
| 3 | | | 6 | | |

Do you use any of the following?

___ Aspirin
___ St. John's Wort
___ Ibuprofen (Advil, Motrin)
___ Tylenol
___ Laxatives
___ Stool softeners
___ Iron
___ Vitamins
___ Birth control pills
___ Blood thinners (Coumadin, Plavix, Heparin)
___ Hormones: _____
___ Other arthritis medications: _____
___ Herbal supplements: _____

PROBLEM LIST/MEDICAL HISTORY: Please check all that pertain to yourself

| | | | |
|---|---|---|---|
| ____ Autoimmune disease | ____ Diverticulosis | ____ HIV/AIDS | ____ Stroke / CVA |
| ____ Alcoholism | ____ Duodenal ulcer | ____ High blood pressure | ____ Thyroid disease |
| ____ Anemia | ____ Endocarditis | ____ Kidney disease | ____ Ulcerative colitis |
| ____ Arthritis | ____ Gallstones | ____ Liver disease | |
| ____ Asthma | ____ Gastric ulcer | ____ Lung disease | |
| ____ Barrett's | ____ Glaucoma | ____ Neurological disease | *Cancer: please list type: |
| ____ Cancer* | ____ Heart attack | ____ Pancreatitis | _____ |
| ____ Colon polyps | ____ Heart failure | ____ Osteoporosis | _____ |
| ____ Crohn's | ____ Heart murmur | ____ Reflux (GERD) | |
| ____ Depression | ____ Heart valve replacement | ____ Seizures | |
| ____ Diabetes | ____ Hepatitis | ____ Sleep apnea | ☐ No problems |

MISCELLANEOUS QUESTIONS:

| | | |
|---|---|---|
| Are you taking ORAL STEROIDS at this time?<br>If yes, for how long? _____ | YES | NO |
| Have you ever received a BLOOD TRANSFUSION?<br>If yes, please give date: _____ | YES | NO |
| Have you ever been HOSPITALIZED?<br>If yes, please give date and reason: _____ | YES | NO |
| Are you PREGNANT?<br>If yes, give estimated delivery date: _____ | YES | NO |

SURGICAL HISTORY:

| ☐ No surgical history | | | |
|---|---|---|---|
| Appendectomy | Date: | Hysterectomy (please circle):<br>Vaginal / Abdominal | Date: |
| Gall bladder | Date: | | |
| Open heart | Date: | Colon surgery | Date: |
| Heart valve | Date: | Esophageal or<br>stomach surgery | Date: |
| Hernia repair | Date: | | |

PROCEDURE HISTORY:

| ☐ No procedure to date | | |
|---|---|---|
| Procedure | Date | Results |
| Colonoscopy | | |
| Barium enema | | |
| EGD | | |
| Sigmoidoscopy | | |
| Upper GI | | |

FAMILY HISTORY:

| ☐ Family history unknown / Adopted | | | |
|---|---|---|---|
| | Significant health problems | Living or deceased | Age |
| Mother | | | |
| Father | | | |
| Brothers | | | |
| Sisters | | | |
| Daughter | | | |
| Son | | | |

Has any member in your family had any of the following?
If so, please list who and whether your relative is on your mother's or father's side.

| | | | |
|---|---|---|---|
| ☐ Cirrhosis | | ☐ Gallstones | |
| ☐ Colon cancer | | ☐ Gastric cancer | |
| ☐ Colon polyps | | ☐ Liver disease | |
| ☐ Crohn's | | ☐ Pancreatic cancer | |
| ☐ Duodenal ulcer | | ☐ Pancreatitis | |
| ☐ Esophageal cancer | | ☐ Ulcerative colitis | |
| ☐ Gastric ulcer | | ☐ Other | |

SOCIAL HISTORY:

| Occupation: | Marital status: M S D W Sep |
|---|---|
| Alcohol | ☐ None ☐ Occasionally ☐ Moderately ☐ Heavy ☐ Socially ☐ Weekends<br>____ drinks per week ☐ Beer ☐ Wine ☐ Liquor ☐ Recovering alcoholic |
| Tobacco | Do you use tobacco? Yes No Year quit: _____<br>Did you ever smoke? Yes No If so, for how long? _____<br>☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigars Amount per day: _____ |
| Drugs | Do you currently use recreational or street drugs? Yes No<br>If yes, please list type of drug: _____ How often: _____<br>Have you ever given yourself drugs with a needle? Yes No |
| Exercise | ☐ No exercise ☐ Mild exercise ☐ Occasional vigorous exercise ☐ Regular vigorous exercise |
| Diet | Are you on a special diet? Yes No<br>Describe: _____ |
| Caffeine | ☐ None ☐ Coffee ☐ Tea ☐ Cola Number of cups/cans per day: _____ |