

Thyroid Disorders				Cancer						
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HAVE YOU EXPERIENCED ANY OF THE FOLLOWING GASTROINTESTINAL AND / OR HEPATIC SYMPTOMS RECENTLY?

System	TODAY	IN THE PAST TWO MONTHS	PLEASE INDICATE IF THIS ISSUE HAS BEEN RESOLVED BY WRITING "RESOLVED" or you may explain.
<u>Gastrointestinal</u>			
Diarrhea			
Constipation			
Rectal Bleeding			
Change in Bowel Habits			
Weight Loss			
Dark Stools			
Irritable Bowel			
Crohn's Disease			
Ulcerative Colitis			
Trouble Swallowing			
Nausea/Vomiting			
Heartburn			
Abdominal Pain			
<u>HEPATIC</u>			
End Stage Liver Disease			
Cirrhosis			
Hepatitis			
Pancreatitis Acute/Chronic			

<u>PAST GASTROINTESTINAL PROCEDURES:</u>	YES	NO	<u>APPROXIMATE DATE OF PROCEDURE</u>	<u>WERE POLYPS FOUND?</u>	<u>ANY ABNORMAL FINDINGS PLEASE EXPLAIN:</u>
HAVE YOU EVER HAD A COLONOSCOPY IN THE PAST?					
HAVE YOU EVER HAD AN UPPER ENDOSCOPY (EGD)?					
<u>Have you:</u>	YES	NO	<u>APPROXIMATE DATE</u>		
Ever had a blood transfusion?					
Donated blood?					
Do you have tattoos (yr of oldest)					

Have you ever had any surgery or been hospitalized? ___Yes ___No Have you had any problems with anesthesia? ___Yes ___No If yes, please list below	Surgeries	Dates	Hospitalizations other than surgery	Dates
<u>Social History:</u>	Alcohol: How many drinks per day? _____ Per week? _____ Per month? _____ Do you currently use street drugs ___Yes ___No if yes How often? _____ Have you ever used street drugs ___Yes ___No When did you quit? _____			
<u>Tobacco use: Please check one:</u> Non Smoker: _____ Current Smoker _____ Former Smoker _____	Tobacco: How many packs per day? _____ for how many years? _____ At what age did you begin Smoking? _____ Year quit _____			

Please list any allergies, including environmental, medication, food, and reaction to previous blood transfusion.	
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Family History Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions

Condition	Relation	Living/Deceased?	Condition	Relation	Living/Deceased?	Condition	Relation	Living/Deceased?
Colon/ Rectal Cancer No ___ Yes ___			Kidney problems No ___ Yes ___			Heart Disease No ___ Yes ___		
Stomach Cancer No ___ Yes ___			Ulcerative Colitis No ___ Yes ___			Crohn's Disease No ___ Yes ___		
Breast Cancer No ___ Yes ___			Ovarian Cancer No ___ Yes ___			Bleeding Problems No ___ Yes ___		

Please indicate in this section any issues we have not addressed on this form:

*******Patients: please do not sign until the Medical Assistant has gone over this information with you*******

I _____ agree that the information I have provided on this Patient History
 Patient name
 Form is accurate to the best of my knowledge. The Medical Assistant has reviewed the information with me in the room and I agree that this information will become part of my permanent medical record.

 Printed Patient Name

 Today's date

 Patient Signature

FOR OFFICE USE ONLY, PATIENTS PLEASE DO NOT WRITE BELOW THIS LINE

The above information has been reviewed and discussed with the patient:	Date information reviewed	Staff name/Title	Signature
PLEASE CIRCLE ONE YES / NO			
Patient refused: YES / NO	Reason if any:		