PITTSBURGH GASTROENTEROLOGY ASSOCIATES
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PATIENT MEDICAL HISTORY RECORD

Welcome to our practice! Please help us assess your health care needs by providing some basic information about yourself. This ***4 page form*** will become part of your permanent, *confidential* health record.

NAME______________________________
MAIDEN NAME______________________________
DATE OF BIRTH______________________________
SEX: MALE____ FEMALE____

DATE COMPLETED______________________________
REVIEWED BY______________________________
PRIMARY CARE______________________________
PRIMARY CARE PHONE______________________________
REFERRED BY______________________________

• *CHIEF COMPLAINT & HISTORY OF PRESENT ILLNESS:*

• What medical problem or concern brings you here today?______________________________

• When did you first notice this problem?______________________________
• Have you seen any other doctor for this problem? Yes____ No____ If yes, who?______________________________
• Have you ever had this problem in the past? Yes____ No____
• Have you taken any prescribed medicine or over-the-counter drugs for relief? Yes*____ No____
*Please list:______________________________
• Do you experience pain or discomfort? Yes____ No____
*Please describe type of pain, location, when you first noted:______________________________

• Have you had weight loss? Yes____ No____ How much? ___ Over what period of time?____________
• Have you had weight gain? Yes____ No____ How much? ___ Over what period of time?____________
• Do you have regular bowel movements? Yes____ No*____
• Have you noticed any change in your bowel movements? Yes*____ No____
• Have you used laxatives or anti-diarrheal medications? Yes*____ No____
*Please explain:______________________________
• Please list any other symptoms, questions or concerns you would like to discuss with the doctor:____________

• *ALLERGIES*: *Yes* *None Known* *If yes, please list LATEX and all medication allergies, plus reaction*:

• *MEDICATIONS*: Please list all medications you are currently taking, including over-the-counter drugs, vitamins, herbs, aspirin/arthritis medications, etc.

MEDICINE	DOSE	HOW OFTEN USED	ORDERED BY	REASON FOR USE

• Do you take any medications on an empty stomach? Yes____ No____
• Have you recently taken antibiotics? Yes____ No____
• Do you require prophylactic antibiotics prior to dental work or surgical procedures? Yes____ No____

NAME____ DATE OF BIRTH____________________________________

• ***PAST MEDICAL HISTORY***:

• ***Please check if you have been diagnosed or treated for any of the following gastrointestinal disorders:***

BARRETT'S ESOPHAGUS______
BLOOD IN STOOL______
CANCER ______
CIRRHOSIS______
COLITIS______
CROHN'S DISEASE______
DIVERTICULOSIS______
DUODENAL ULCER______
ESOPHAGITIS______
FISTULAS______
FISSURES______
GALLBLADDER DISEASE______
GALLSTONES______
GASTRITIS______
HEMORRHOIDS______
HEPATITIS______
HIATAL HERNIA______
IRRITABLE BOWEL SYNDROME______
JAUNDICE______
LIVER DISEASE______
PANCREATITIS______
PEPTIC ULCER______
POLYPS______
REFLUX______
SPRUE______
STRICTURES______
TUMOR/MASS______
VOMITING BLOOD______

• PLEASE LIST ANY OTHER CONDITIONS NOT LISTED ABOVE:____

• ***HOSPITALIZATIONS AND OPERATIONS***: *Please list all hospitalizations, procedures and surgical operations, including admitting physician, date, location and reason or diagnosis.*

• **Have you ever had any blood transfusions? Yes____ No____ When?__________________________**

OPERATION OR REASON FOR ADMISSION	DATE/YEAR	PHYSICIAN	HOSPITAL

• ***FAMILY MEDICAL HISTORY***:

• ***Please "check" if your parents, siblings, grandparents, aunts, uncles or children had any of the following:***

ANEMIA______
BLEEDING PROBLEM______
CELIAC______
CIRRHOSIS______
COLITIS______
COLON CANCER______
COLON POLYPS______
CROHN'S DISEASE______
DIABETES______
HEART DISEASE______
LIVER DISEASE______
PEPTIC ULCERS______
TUBERCULOSIS______
OTHER CANCER______
OTHER:__________________________
____

PLEASE COMPLETE	AGE IF LIVING	CHECK IF HEALTHY	AGE AT DEATH	LIST MAJOR ILLNESS OR CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS/				
SISTERS				
CHILDREN				

NAME____ DATE OF BIRTH____________________________________

PLEASE CHECK ALL SYMPTOMS THAT YOU ARE EXPERIENCING:

GASTROINTESTINAL:

- ❑ NAUSEA OR VOMITING
- ❑ VOMITING BLOOD
- ❑ DRY HEAVES
- ❑ HEARTBURN
- ❑ BELCHING OR REGURGITATION
- ❑ SOUR OR BITTER TASTE
- ❑ INCREASE/DECREASE IN APPETITE
- ❑ EXCESSIVE GAS OR BLOATING
- ❑ FEELING OF "LUMP" IN THROAT
- ❑ PAINFUL SWALLOWING
- ❑ DIFFICULTY SWALLOWING
- ❑ CHOKE OR COUGH AFTER EATING
- ❑ INDIGESTION
- ❑ ABDOMINAL PAIN OR CRAMPS
- ❑ CONSTIPATION
- ❑ DIARRHEA
- ❑ CHANGE IN YOUR BOWEL HABITS
- ❑ CHANGE IN COLOR OR SIZE OF STOOLS
- ❑ BLOOD IN STOOL
- ❑ POSITIVE HEMOCCULT TEST
- ❑ MUCOUS IN STOOLS
- ❑ DARK/TARRY STOOLS
- ❑ FOUL ODOR TO STOOLS
- ❑ PAINFUL BOWEL MOVEMENTS
- ❑ FECAL INCONTINENCE
- ❑ HEMORRHOIDS
- ❑ JAUNDICE/"YELLOW" SKIN/EYES
- ❑ HISTORY OF HEPATITIS

CONSTITUTIONAL/GENERAL:

- ❑ RECENT WEIGHT LOSS
- ❑ RECENT WEIGHT GAIN
- ❑ FEVER WITHIN PAST MONTH
- ❑ CHILLS OR SWEATS
- ❑ FATIGUE OR WEAKNESS

EYES:

- ❑ BLURRED OR DOUBLE VISION
- ❑ CATARACTS
- ❑ GLAUCOMA
- ❑ GLASSES OR CONTACTS

EARS, NOSE, MOUTH, THROAT:

- ❑ HEARING LOSS/HEARING AID
- ❑ RINGING IN THE EARS
- ❑ SORE THROAT/HOARSENESS
- ❑ SINUS PROBLEM
- ❑ NOSE BLEEDS

CARDIOVASCULAR:

- ❑ CHEST PAIN OR PRESSURE
- ❑ RAPID OR IRREGULAR HEART BEAT
- ❑ SWELLING IN LEGS OR FEET
- ❑ HISTORY OF HIGH BLOOD PRESSURE
- ❑ HISTORY OF VALVULAR DISEASE
- ❑ CORONARY ARTERY DISEASE
- ❑ ARTIFICIAL HEART VALVE
- ❑ ABDOMINAL AORTIC ANEURYSM
- ❑ HISTORY OF ENDOCARDITIS
- ❑ HISTORY OF STROKE
- ❑ HISTORY OF VASCULAR DISEASE

ENDOCRINE:

- ❑ EXCESSIVE THIRST/URINATION
- ❑ HISTORY OF DIABETES
- ❑ HISTORY OF THYROID DISEASE

RESPIRATORY:

- ❑ SHORTNESS OF BREATH
- ❑ WHEEZING OR ASTHMA
- ❑ PERSISTENT COUGH/COLDS
- ❑ COUGHING UP SPUTUM/BLOOD
- ❑ TUBERCULOSIS/OR EXPOSURE TO
- ❑ BRONCHITIS

MUSCULOSKELETAL:

- ❑ PAIN/STIFF/SWOLLEN JOINTS
- ❑ PAIN/STIFFNESS IN NECK
- ❑ BACKACHE
- ❑ MUSCLE WEAKNESS
- ❑ OSTEOPOROSIS
- ❑ ARTHRITIS
- ❑ ARTIFICIAL JOINT

GENITOURINARY:

- ❑ FREQUENT URINATION
- ❑ DIFFICULTY URINATING
- ❑ LEAKING URINE
- ❑ BURNING ON URINATION
- ❑ BLOOD IN URINE
- ❑ URINARY TRACT INFECTION
- ❑ STONES/KIDNEY PROBLEMS
- ❑ SEXUALLY CONTRACTED DISEASE
- ❑ LAST PROSTATE EXAM________________
- ❑ LAST MENSTRUAL PERIOD_____________
- ❑ LAST PAP SMEAR_____________________
- ❑ LAST MAMMOGRAM___________________
- ❑ LAST SCREENING COLONOSCOPY________

SKIN:

- ❑ SKIN RASHES/ITCHING/HIVES
- ❑ TATTOO
- ❑ BREAST TENDERNESS
- ❑ LUMP IN BREAST
- ❑ PRIOR BREAST BIOPSY

ALLERGIES/IMMUNOLOGY:

- ❑ ALLERGIES TO MEDICATIONS
- ❑ ALLERGIES TO LATEX
- ❑ OTHER ALLERGIES
- ❑ POSITIVE FOR HIV OR AIDS

NEUROLOGICAL:

- ❑ HEADACHES
- ❑ HISTORY OF MIGRAINE HEADACHES
- ❑ DIZZINESS
- ❑ EQUILIBRIUM PROBLEMS
- ❑ NUMBNESS OR TINGLING
- ❑ SEIZURES
- ❑ SLURRED SPEECH
- ❑ FAINTING OR "BLACKING OUT"

HEMATOLOGIC/LYMPHATIC:

- ❑ ENLARGED GLANDS
- ❑ BRUISE EASILY
- ❑ ABNORMAL BLEEDING
- ❑ ANEMIA
- ❑ HISTORY OF BLOOD TRANSFUSION
- ❑ HISTORY OF CANCER OR TUMOR

MENTAL HEALTH:

- ❑ ANXIETY
- ❑ DEPRESSION
- ❑ CONFUSION
- ❑ MEMORY LOSS
- ❑ HISTORY OF ALCOHOL ABUSE
- ❑ HISTORY OF DRUG ABUSE
- ❑ PROBLEMS SLEEPING

OTHER SYMPTOMS NOT LISTED:

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NAME____ DATE OF BIRTH____________________________________

SOCIAL HISTORY:

- ***MARITAL STATUS***: Single____ Married____ Widowed____ Divorced____

- ***FAMILY***: Number of children_______ Ages____
  Do you live alone? Yes____ No____ Number Living at Home_____ Pets? Yes____ No____
  List any problems with living arrangements____ None____

- ***OCCUPATION***: Present Position____
  Have you had any exposures to industrial hazards, radiation, caustic or chemical agents? Yes____ No____

- ***EXERCISE***: Do you exercise regularly? Yes____ No____
  List type, amount, frequency:____
  ____

- ***SLEEP***: Number of hours per night_______ Do your symptoms disturb your sleep? Yes____ No____

- ***DIET***: Have you had a recent change in your diet? Yes____ No____
  Have you had a change in your appetite? Yes____ No____
  Do you eat 3 meals per day? Yes____ No____ Do you eat late at night? Yes____ No____
  Do you consume "diet" products, such as diet gum, soda, in large amounts? Yes____ No____
  Do you consume coffee, tea, caffeinated products regularly, including chocolate, cola? Yes____ No____
  If yes, list product and approximate daily consumption:____
  Have you recently eaten raw shellfish? Yes____ No____
  Do you suspect you are a victim of food poisoning? Yes____ No____
  Do you have any food intolerance or allergies to foods? Yes____ No____ Describe___________________________________

- ***TOBACCO USE***: Do you smoke or use smokeless tobacco? Yes____ No____
  If yes, please check all that apply: Cigarettes____ Cigars____ Smokeless Tobacco____
  Age started using tobacco or how long you have used____
  If former user, please complete above and state when you started/stopped____________________________________

- ***ALCOHOL USE***: Do you drink alcohol? Yes____ No____
  If yes, list product and approximate weekly consumption____

- ***ENVIRONMENT***: Do your daily activities cause you stress? Yes*____ No____
  Are there any social or environmental factors which may have contributed to your illness? Yes*____ No____
  Have you ever been a victim of sexual, mental, physical, or child abuse? Yes*____ No____
  Do you engage in behaviors* which may place your health at risk? Yes*____ No____

**Such as use of IV or street drugs, homosexual/bisexual behavior, or sexual activity with someone known or suspected of having a contagious disease, such as hepatitis or AIDS. This information is strictly confidential, but it is very important that the doctor be aware of this history to provide you the best care.*

*If you answered yes to any of the above questions, please explain____

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