

# History Form for Revisit

## 1. Please enter the patient's information.

First (legal) Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Female  Male

## 2. Primary Care Physician:

Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Phone: \_\_\_\_\_

## 3. What medical problem or concern do you have?

\_\_\_\_\_  
Please describe any updates regarding the above issue:

\_\_\_\_\_  
Any other questions or concerns you would like to discuss?

## 4. Please list updates on your health status since your last visit. Include newly diagnosed diseases, problems.

\_\_\_\_\_  
Please list updates on admissions, surgeries since your last visit. Include date, doctor, hospital and reason.

## 5. Have you had the following tests or any updates since your last visit? If yes, please list the last test: when, where, and ordered by whom? We will try to obtain the records.

- Colonoscopy:
- Upper Endoscopy (EGD):
- Abdominal Ultrasound:
- Abdominal CT scan:
- Abdominal MRI:
- Blood Work:

## 6. Please update all medications you are currently taking, including over-the-counter drugs, vitamins, herbs, aspirin, arthritis medications, etc. Describe Medication Name, Dose, Frequency, Ordered by, and Reason for Use.

**7. Please update any allergies (including latex) and reaction.**

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**8. Please check your gastrointestinal symptoms:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abdominal Pain or Cramps        | <input type="checkbox"/> Nausea                  | <input type="checkbox"/> Vomiting                     |
| <input type="checkbox"/> Vomiting Blood                  | <input type="checkbox"/> Heartburn / Acid Reflux | <input type="checkbox"/> Sour or Bitter Taste         |
| <input type="checkbox"/> Regurgitation                   | <input type="checkbox"/> Belching                | <input type="checkbox"/> Lumpy Feeling in Throat      |
| <input type="checkbox"/> Difficult Swallowing            | <input type="checkbox"/> Painful Swallowing      | <input type="checkbox"/> Food Getting Stuck           |
| <input type="checkbox"/> Choke or Cough after Swallowing | <input type="checkbox"/> Bloating                | <input type="checkbox"/> Excessive Gas                |
| <input type="checkbox"/> Indigestion                     | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Diarrhea                     |
| <input type="checkbox"/> Change in Bowel Habits          | <input type="checkbox"/> Change in Size of Stool | <input type="checkbox"/> Blood in Stool               |
| <input type="checkbox"/> Dark or Tarry Stool             | <input type="checkbox"/> Mucus in Stool          | <input type="checkbox"/> Foul Odor to Stool           |
| <input type="checkbox"/> Stool Incontinence or Leaking   | <input type="checkbox"/> Hemorrhoids             | <input type="checkbox"/> Anal Itching                 |
| <input type="checkbox"/> Anal Burning                    | <input type="checkbox"/> Decrease in Appetite    | <input type="checkbox"/> Food Intolerance/Sensitivity |
| <input type="checkbox"/> Jaundice/Yellow Skin or Eyes    | <input type="checkbox"/> Unexplained Weight Gain | <input type="checkbox"/> Unexplained Weight Loss      |

**9. List any other symptoms:**

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**10. Has any of your parents or siblings been diagnosed with colon cancer or GI disease since last visit?**

Yes.  No.  If yes, please explain:

**11. Do you smoke?**

Yes  No  Past

**12. Do you drink alcohol?**

Yes.  No.  Past (quit date: \_\_\_\_\_).  If yes, list products and approximate weekly consumption:

**13. Diet**

Do you consume coffee, tea, caffeinated products regularly, including chocolate, cola?

Yes  No

Do you often consume artificial sweeteners?

Yes  No

Do you have any food intolerance or allergies to foods?

Yes.  No.  If yes, please explain:

**14. Do you use recreational drugs or medical marijuana?**

Yes.  No.  If yes, please explain:

**15. Other Questions**

When was last flu shot?

Last pneumonia shot?

Height

Weight

Occupation

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**16. Are there any questions, concerns, or anything else you want us to know? Please describe.**

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