Richmond Gastroenterology Associates

HEALTH HISTORY

(Confidential)

Name ____ Today's Date__________________ Age ______

Date of last physical exam ___________ What is the reason for your visit?____

SYMPTOMS Check (√) symptoms you currently have or have had in the past 3 to 4 months.

GENERAL
- ☐ chills
- ☐ night sweats
- ☐ fever
- ☐ weight loss
- ☐ difficulty sleeping
- ☐ fatigue

EYE, EAR, NOSE, THROAT
- ☐ bleeding gums
- ☐ blurred vision
- ☐ crossed eyes
- ☐ difficulty swallowing
- ☐ double vision
- ☐ earache
- ☐ ear drainage
- ☐ hay fever
- ☐ hoarseness
- ☐ loss of hearing
- ☐ nosebleeds
- ☐ fullness in the throat
- ☐ ringing in ears
- ☐ sinus problems
- ☐ see flashing lights or halos
- ☐ glasses ☐ contacts
- ☐ sore throat

NEUROLOGICAL
- ☐ headaches
- ☐ dizziness
- ☐ seizures
- ☐ fainting
- ☐ weakness in arms or legs
- ☐ tremors
- ☐ numbness

CARDIOVASCULAR
- ☐ chest pains
- ☐ irregular heart beat
- ☐ palpatations
- ☐ ankle swelling
- ☐ varicose veins
- ☐ rapid heart rate
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ pain in legs while walking

PULMUONARY
- ☐ shortness of breath
- ☐ wheezing
- ☐ persistent cough

GASTROINTESTINAL
- ☐ poor appetite
- ☐ bloating
- ☐ bowel changes
- ☐ constipation
- ☐ diarrhea
- ☐ problems with gas
- ☐ indigestion
- ☐ nausea
- ☐ rectal bleeding
- ☐ abdominal pain
- ☐ vomiting
- ☐ yellow jaundice
- ☐ trouble swallowing food or pills
- ☐ black tarry stools
- ☐ blood in stools
- ☐ lack of bowel control
- ☐ regurgitation
- ☐ reflux

MUSCLE, JOINT, BONE

Pain, weakness or numbness in:
- ☐ arms ☐ hips
- ☐ back ☐ legs
- ☐ feet ☐ neck
- ☐ hands ☐ shoulders

GENITO-URINARY
- ☐ blood in urine
- ☐ frequent urination
- ☐ lack of bladder control
- ☐ painful urination
- ☐ kidney or urinary infections
- ☐ getting up more than 1-2 times at night to urinate

PSYCHIATRIC
- ☐ depression
- ☐ anxiety
- ☐ panic attacks
- ☐ mood swings
- ☐ memory loss

LYMPH/HEMATOLOGICAL
- ☐ low blood count
- ☐ easy bruising
- ☐ easy bleeding
- ☐ swollen lymph nodes

ENDOCRINE
- ☐ excessive hunger
- ☐ excessive thirst
- ☐ intolerance to heat or cold
- ☐ excessive sweating
- ☐ excessive urination
- ☐ thyroid problems
- ☐ blood sugar problems

MEN only
- ☐ breast lump
- ☐ erection difficulties
- ☐ lump in testicles
- ☐ penis discharge
- ☐ sore on penis
- ☐ prostate problems

WOMEN only
- ☐ abnormal pap smear
- ☐ bleeding between periods
- ☐ breast lump
- ☐ extreme menstrual pain
- ☐ hot flashes
- ☐ nipple discharge
- ☐ painful intercourse
- ☐ vaginal discharge
- ☐ other

Date of last menstrual period___________

Date of last pap smear ________________

Do you take birth control pills? ☐ yes ☐ no

Date of last mammogram______________

SKIN
- ☐ hives
- ☐ itching
- ☐ rash
- ☐ changes in moles
- ☐ sores that won't heal
- ☐ other skin problems?

Do you take blood thinners? ☐ Aspirin ☐ Coumadin/Warfarin ☐ Plavix/Clopidogrel ☐ Ticlid/ticlodipine

Do you take any of these medications? ☐ Aspirin ☐ Ibuprofen, Motrin or Advil ☐ Alleve/Naprosen ☐ BC/Goody powders ☐ Nupren ☐ Rufen ☐ Alkaseltzer ☐ Ascriptin ☐ Voltaren ☐ Ansaid ☐ Dolobid ☐ Indocin ☐ Feldene ☐ Relafen ☐ Clinoril ☐ Bufferin ☐ Torodol ☐Arthrotec ☐ Lodine

Are you taking any herbal or vitamin supplements? ☐ yes ☐ no

CONDITIONS Check (√) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Crohn's disease
- ☐ colitis
- ☐ cysts on ovaries
- ☐ Diabetes
- ☐ diverticulosis/diverticulitis
- ☐ Emphysema (COPD)
- ☐ Epilepsy
- ☐ Gallbladder problems
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart attack
- ☐ Heart rhythm problems
- ☐ Heart valve problems
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease/problems
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pacemaker/defibrillator
- ☐ Pancreatitis
- ☐ Pneumonia
- ☐ Prostate problems
- ☐ Psychiatric care
- ☐ Rheumatic Fever
- ☐ Stroke/ Mini-Stroke
- ☐ Suicide Attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

Name ________________________________ Chart Number____________________

RICHMOND GASTROENTEROLOGY ASSOCIATES, INC

Past Medical History Questionnaire

(All information is strictly confidential)

DOB ____________________

Fill in health information about your health and the health of your blood relatives.

Check (√) if your blood relatives had any of the following:		
	Disease	Relationship to you
	Arthritis or Gout	
	Asthma or Emphysema	
	Cancer of Breast	
	Cancer of Colon	
	Cancer of Pancreas	
	Cancer – other	
	Chemical Dependency	
	Crohn's or Colitis	
	Colon Polyps	
	Diabetes	
	Heart Disease	
	High Blood Pressure	
	Kidney Disease	
	Strokes	
	Tuberculosis	
	Ulcer disease	

List current mediations you are taking

Hospitalizations Year	Hospital	Reason for Hospitalization and outcome

Serious illnesses/injuries	Date	Outcome

Allergies to Medications or Substances

Health Habits Check (√) which substances you use and describe how much.		
	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	

Occupational Concerns Check (√) if your work exposes you to the following.	
	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Have you ever had a blood transfusion or plasma? ☐ **Yes** ☐ **No**

If yes, please give approximate dates:

Your occupation: