NORTHERN ARIZONA GASTROENTEROLOGY, P.C.

Health History

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Name		D.O.B	Age
Referring Doctor or PCP	Preferred Pharmacy	Location	Date
Reason For Visit	Preferred Lab	Location	

Patient Health History Which of these gastrointestinal symptoms do you experience on a regular basis?

- ☐ Abdominal Pain
- ☐ Difficulty Swallowing solids or liquids
- ☐ Persistent Nausea and/or vomiting
- ☐ Loss of Appetite
- ☐ "Back-wash" of stomach contents into the mouth
- ☐ Any Black or Tarry Stools
- ☐ Rectal Pain or Itching
- ☐ Mucous Stools
- ☐ Chronic Diarrhea
- ☐ Gas, Bloating, or Belching
- ☐ Constipation
- ☐ Whole Body Itching
- ☐ Vomiting Blood or Coffee Grounds
- ☐ Spastic Colon/Irritable Bowel
- ☐ Heartburn
- ☐ Blood from Rectum

☐ Yes ☐ No ☐ N/A Stool test positive for blood in last 6 months

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS?

GENERAL
- ☐ Loss of appetite
- ☐ More thirsty lately
- ☐ Armpits or groin swelling
- ☐ Difficulty sleeping
- ☐ Drenching night sweats
- ☐ Fatigue
- ☐ Shaking chills
- ☐ Fever
- ☐ Medication Changes
- ☐ Weight gain
- ☐ Weight loss

Skin
- ☐ Itching or burning skin
- ☐ Bleeds easily
- ☐ Bruises easily
- ☐ Skin rash

HEENT
- ☐ Headaches
- ☐ Sinus problems
- ☐ Enlarged tonsils
- ☐ Hoarse voice
- ☐ Dry mouth
- ☐ Dental problems
- ☐ Swelling gums or jaw problem
- ☐ Mouth sores or ulcers
- ☐ Hearing difficulties
- ☐ Buzzing in ears
- ☐ Pain in ears
- ☐ Trouble with eyes or vision
- ☐ Dry eyes
- ☐ Nosebleeds
- ☐ Sore throat

Neck
- ☐ Neck pain
- ☐ Neck lumps or swelling
- ☐ Swollen glands

Respiratory
- ☐ Chronic cough
- ☐ Cough up phlegm
- ☐ Cough up blood
- ☐ Wheezing

Cardiovascular
- ☐ Racing heart
- ☐ Chest discomfort
- ☐ Dizzy spells/ fainting
- ☐ Short of breath
- ☐ Short of breath at night
- ☐ More pillows to breathe
- ☐ Swollen feet or ankles

Genital (Men Only)
- ☐ Weak urine stream
- ☐ Burning/discharge
- ☐ Prostate trouble
- ☐ Lumps on testicles
- ☐ Painful testicle
- ☐ Hernia

Genital (Women only)
- ☐ Painful menstruation
- ☐ Excess menstruation
- ☐ Bleed between periods
- ☐ Painful intercourse

Urinary
- ☐ Night frequency
- ☐ Day frequency
- ☐ Incontinence
- ☐ Bloody urine
- ☐ Difficulty starting urine
- ☐ Burning on urination

Musculoskeletal
- ☐ Aching muscles or joints
- ☐ Swollen joints
- ☐ Back or shoulder pain

Mood
- ☐ Lonely or depressed
- ☐ Memory loss
- ☐ Alcohol problem
- ☐ Drug problem
- ☐ Cries often
- ☐ Lack of concentration

Hematology
- ☐ Anemia
- ☐ Blood Clots

Past Medical History Check any illnesses you have had. Please state when

Cardiac Disease	Date	GI Disease	Date	Lung Disease	Date	Kidney	Date
☐ Pacemaker ☐ Heart Valve ☐ Mitral Valve Prolapse ☐ Heart Attack ☐ Heart Failure ☐ A-Fib		☐ Ulcer ☐ Heartburn ☐ Pancreatitis ☐ Diverticulosis ☐ Irritable Bowel (Spastic Colon) ☐ Hemorrhoidal Bleeding ☐ H Pylori		☐ Asthma ☐ Tuberculosis ☐ Hay Fever ☐ Emphysema		☐ Kidney Stones ☐ Pain When urinating ☐ Blood in Urine	

Cancer		Liver Disease		Misc		Misc (cont.)	
☐ Type?:		☐ Hepatitis ☐ Cirrhosis ☐ Yellow Jaundice ☐ Alcoholism		☐ Arthritis ☐ Anemia ☐ Thyroid Disease ☐ High Blood Pressure		☐ Diabetes ☐ Stroke ☐ Glaucoma ☐ Depression	

Surgeries Type of surgery and year.

	Year		Year		Year
1.		3.		5.	
2.		4.		6.	

Medications You Have Allergies To: What type of reaction did patient have?_____

1. 2. 3. 4.

Immunizations: Flu ___ Month _____ Year _____ Pneumovax ___ Month _____ Year _____ Hepatitis A B Month _____ Year _____

Family History Check if any of your blood relatives have had any of the following:

	Mother	Father	Brothers	Sisters
Esophageal Cancer	☐	☐	☐	☐
Ulcer	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐
Jaundice	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐

	Mother	Father	Brothers	Sisters
Pancreatic Cancer	☐	☐	☐	☐
Crohn's or Ulcerative Colitis	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐

	Mother	Father	Brothers	Sisters
Heart Attack	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐
Bladder Cancer	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐

Other Cancer (type)_____

(person)_____

Social History

Occupation	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Do you consume Alcohol ☐ Yes ☐ No Drinks Per Day _____	Have you been outside of the US in the last 12 months If yes, where _____ when _____ ☐ Yes ☐ No
Do you have a history of Alcohol Abuse ☐ Yes ☐ No When _____ How Much _____	Do you have a history of Drug Use? ☐ Yes ☐ No When _____ How Much _____
Do you use tobacco? ☐ Yes ☐ No How many packs per day _____	Do you smoke medical marijuana? ☐ Yes ☐ No Recreational? ☐ Yes ☐ No
Have you quit smoking? ☐ Yes ☐ No ☐ N/A When	How many years did you smoke

Current Medications

Name	Strength	Dosage Instructions
Example: XXXXXXX	*# mg*	*# pills # times daily*

GYN History (Women Only): Number of pregnancies_____ Number or births_____ Last menstrual period _____

List any abdominal x-rays, scans or labs done in the last year & the facility where the tests were completed, since your last visit.

Recent ER visits?

Other Medical History

Have you ever had a sigmoidoscopy or colonoscopy? Year_____ Location _____ Upper Endoscopy? Year_____ Location_____	Have you ever received blood transfusions in the past? No Yes (when?)_____ (please circle no or yes)