***Providing Information About Your Health Is Very Important. Please Take the Time To Fully Complete This Form.***

Coastal gastroenterology PC

## MEDICAL & FAMILY HISTORY FORM

**NAME:** _____ **DATE OF BIRTH:** _____ **TODAY'S DATE:** _____

**Reason for Visit:**_____ **Primary Doctor:**_____

**Vaccinated for Co-Vid 19: YES NO Vaccine Name:** _____

**Medications** — Please list all of your current prescription and non-prescription medications, vitamins and supplements OR let us copy a pre-existing list) **Pharmacy Name:**_____

| | | |
|---|---|---|
| NONE ☐ | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Past Medical History**

| | | | | |
|---|---|---|---|---|
| ☐Acid reflux | ☐Cirrhosis of liver | ☐Groin hernia | ☐Kidney infection | ☐Polio |
| ☐Anemia | ☐Colon cancer | ☐Heart attack | ☐Kidney stones | ☐Psoriasis |
| ☐Arthritis | ☐Colon polyps | ☐Heart failure | ☐Lupus | ☐Radiation therapy |
| ☐Asthma | ☐Crohn's disease | ☐Heart murmur | ☐Migraines | ☐Rheumatic fever |
| ☐Bleeding disorder | ☐Depression | ☐Hepatitis | ☐Milk intolerance | ☐Sciatica |
| ☐Blood clots | ☐Diabetes | ☐Hiatal hernia | ☐Multiple sclerosis | ☐Seizures |
| ☐Blood transfusion | ☐Diverticulitis | ☐High blood pressure | ☐Osteoporosis | ☐Sleep apnea |
| ☐Chest pain/angina | ☐Duodenal ulcer | ☐High cholesterol | ☐Ovarian cyst | ☐Stomach ulcer |
| ☐Chronic anxiety | ☐Emphysema | ☐High triglycerides | ☐Pancreatitis | ☐Stroke or paralysis |
| ☐Chronic cough | ☐Fatty liver | ☐HIV or AIDS | ☐Parkinson's disease | ☐TB (Tuberculosis) |
| ☐Chronic lung disease | ☐Gallstones | ☐Irregular heart beat | ☐Peptic ulcer | ☐TB skin test positive |
| ☐Chronic sinusitis | ☐Glaucoma | ☐Irritable bowel syndrome | ☐Phlebitis | ☐Thyroid disease |
| ☐Cancer type:_____ | ☐Gout | ☐Kidney disease/failure | ☐Pneumonia | ☐Ulcerative colitis |

**Allergies (**Please indicate Reaction to each Allergy**)**

☐**None** ☐Penicillin ☐Sulfa ☐Aspirin ☐Iodine ☐Latex ☐Codeine

_____ _____ _____ _____ _____ _____

☐Others: _____

**Surgeries/Procedures**

| | | | | | |
|---|---|---|---|---|---|
| ☐**None** | ☐Colostomy | ☐Groin hernia | ☐Hemorrhoid surgery | ☐Liver biopsy | ☐Stomach |
| ☐Appendectomy | ☐C-section | ☐Heart bypass | ☐Hiatal hernia repair | ☐Obesity surgery | ☐Thyroid |
| ☐Breast | ☐EGD | ☐Heart stent | ☐Hysterectomy | ☐Ovary | ☐Tonsillectomy |
| ☐Colon surgery | ☐ERCP | ☐Heart valve | ☐Joint replacement | ☐Prostate | ☐Tubal ligation |
| ☐Colonoscopy | ☐Gallbladder | | ☐Kidney | ☐Sigmoidoscopy | ☐Uterus |

**Date of last Colonoscopy:** _____ Other Sx:_____

**Have you EVER had any colon polyps on past colonoscopies?**_____

**Did you have a POSITIVE COLOGUARD or FIT TEST? (circle answer) NO YES DATE:** _____

**Name:** _____

**DOB:** _____ **Date:** _____

Coastal Gastroenterology PC

| **Family History** | Father | Mother | Grandparents | Siblings | Children |
|---|---|---|---|---|---|
| Healthy | ☐ | ☐ | ☐ | ☐ | ☐ |
| Deceased | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colon polyps | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colon cancer | ☐ | ☐ | ☐ | ☐ | ☐ |

**Social History**

Marital status ☐married ☐single ☐separated ☐divorced ☐widowed ☐partnered

Occupation: _____ ☐unemployed ☐retired

1) Smoking history: ☐never ☐yes; _____ packs per day for _____ years **Age started** _____ **stopped**_____

2) Other tobacco use ☐no ☐yes; details: _____

3) Alcohol use in

PAST 12 Months ☐no ☐yes; # Drinks _____ DAY MONTH YEAR

4) Drug use ☐no ☐yes; specify drugs and amounts: _____

Exercise ☐no ☐yes; how much and how often: _____

Hobbies ☐none ☐yes; specify: _____

Recent travel outside US? ☐no ☐yes; where: _____

**Review of Systems – check all that apply at the *present* time**

**General**
☐fever or chills
☐loss of appetite
☐weight gain
☐weight loss
☐weakness, fatigue

**Gastrointestinal**
☐abdominal distention
☐abdominal pain/cramping
☐belching
☐black stools
☐blood in stool
☐change in bowel habits
☐constipation
☐diarrhea
☐difficulty swallowing
☐fat intolerance
☐full after eating small amounts
☐gas/bloating
☐heartburn
☐indigestion
☐hemorrhoids
☐jaundice
☐nausea or vomiting
☐pain with swallowing
☐poor appetite
☐rectal bleeding
☐rectal pain
☐regurgitation of food
☐soiling/incontinence
☐vomiting blood

**Cardiovascular**
☐chest pain or tightness
☐rapid or irregular heart beat
☐shortness of breath
☐swelling of legs
☐varicose veins

**Respiratory**
☐chronic cough
☐wheezing
☐shortness of breath
☐need for oxygen therapy

**Urinary**
☐pain or difficulty with urination
☐frequent urination
☐blood in urine
☐incontinence of urine

**Musculoskeletal**
☐stiff or painful joints
☐swollen joints
☐back pain
☐muscle pain

**Hematologic**
☐frequent bruising
☐bleeding doesn't stop easily

**Endocrine**
☐heat or cold intolerance
☐excessive thirst or urination
☐steroid therapy (prednisone)

**Genitoreproductive - Male**
☐discharge from penis
☐testicular pain or lump

**Genitoreproductive - Female**
☐heavy periods
date of last period: _____

**Dermatologic**
☐rash or hives
☐itching
☐tattoos

**Neurologic**
☐numbness or tingling
☐dizziness or lightheadedness
☐vertigo
☐headaches
☐weakness in arms or legs
☐blurred vision
☐difficulty with memory

**Psychiatric**
☐anxiety
☐depression
☐panic attacks
☐tired on waking up in morning

**Immunizations**
☐Hepatitis A
☐Hepatitis B