GASTROENTEROLOGY
PERSONAL MEDICAL HISTORY

LITTLE RIVER HEALTHCARE
KING'S DAUGHTERS
CLINIC

PLACE STICKER HERE

Office Use Only
BP: _____
HR: _____
T: _____
Wt: _____

YOUR INFORMATION

Primary Provider: Your Age:
Home Number: Cell Number:

CURRENT DIGESTIVE PROBLEMS

Please describe your current problem(s):

- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Abdominal Pain
- ☐ Difficulty Swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool
- ☐ Black Tarry Stool
- ☐ Weight Loss
- ☐ Previous Ulcer

PREVIOUS COLONOSCOPY? ☐YES / ☐NO

Have you ever received a blood transfusion?

Family History of any of the following cancers:

- ☐ Throat cancer
- ☐ Esophageal cancer
- ☐ Stomach cancer
- ☐ Pancreatic cancer
- ☐ Liver cancer
- ☐ Colon cancer

PAST SURGERIES & PROCEDURES

Surgery:	Date:	Surgery:	Date:
Surgery:	Date:	Surgery:	Date:
Surgery:	Date:	Surgery:	Date:

SOCIAL HISTORY

Caffeinated drinks per day: Packs of cigarettes per day: For how long: When did you quit:

Which alcoholic beverage (if any) do you drink? Amount you drink per day:

Illegal drugs use in the past or now? Which drugs:

Occupation: Place of Employment:

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

With whom do you live? Number of children:

YOUR SELF

	(Check One)
Diabetes:	☐Y / ☐N
High blood pressure:	☐Y / ☐N
Heart problem:	☐Y / ☐N
Lung problem:	☐Y / ☐N
Shortness of breath:	☐Y / ☐N
Cancer (which organ):	☐Y / ☐N
Anemia:	☐Y / ☐N
Arthritis, (which joint):	☐Y / ☐N
Seizures:	☐Y / ☐N
Stroke:	☐Y / ☐N
Urination problems (what kind):	☐Y / ☐N
Liver Disease:	☐Y / ☐N
Changes with hearing or vision:	☐Y / ☐N
Skin rash:	☐Y / ☐N
Headaches:	☐Y / ☐N
Fever:	☐Y / ☐N

ALLERGIES (list below):

YOUR FAMILY

Condition	Relationship (Father, Mother, Etc.)
☐ High blood pressure	
☐ Heart problem	
☐ Cancer (which organ)	
☐ Colon polyps	
☐ Gallbladder problems	
☐ Chronic diarrhea	
☐ Blood disorders	
☐ Liver disease	
☐ Arthritis	
☐ Seizures	
☐ Migraine	
☐ Diabetes	
☐ Stroke	