Banner Health®

NEW PATIENT MEDICAL HISTORY
GASTROENTEROLOGY

Patient Name: ____ **Date of Birth:** ___________________________

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): ____

Primary Care Provider

Name: ____ Phone #: ________________________

Address: ____ Fax #: __________________________

What is the primary reason for your visit? ____

ALLERGIES

❑ No Known Allergies List any allergies and intolerances to **medications, food or the environment.**

Allergy:	Reaction:

MEDICATIONS

List any medications, vitamins, supplements, and over the counter medications you are taking, with dose and how often.

❑ Not taking any medications

Medication Name:	Dose:	How often?	Refill needed (Y/N)?

IMMUNIZATIONS

Have you had a Hepatitis A vaccine? ❑ Yes ❑ No If yes, date: ______________________________

Have you had a Hepatitis B vaccine? ❑ Yes ❑ No If yes, date: ______________________________

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DIAGNOSTIC TESTS

Enter last completion date and whether the result was normal.

TEST:	DATE:	NORMAL (Y/N):	TEST:	DATE:	NORMAL (Y/N):
Bone Density:			Colonoscopy:		

Females Only:

Last Menstrual Period: ____________________ Normal? No _____ Yes _____

# of Pregnancies _____ # of Births _____

MEDICAL HISTORY

What **medical** problems have you had? Please mark **all** that apply:

	CONDITION:	ONSET DATE:		CONDITION:	ONSET DATE:		CONDITION:	ONSET DATE:
	Allergies			COPD			Hepatitis / liver disease	
	Anemia			Coronary artery disease			Hypertension	
	Angina			Depression			Irritable bowel disease	
	Anxiety			Diabetes			Inflammatory bowel disease	
	Arthritis			Elevated lipids			Myocardial infraction	
	Asthma			Gallbladder disease			Osteoporosis	
	Atrial fibrillation			GERD			Renal disease	
	Blood clots			Headache, migraine			Seizure disorder	
	Cancer			Heart disease			Stroke	
	Cardiac arrhythmia			Heart valve disorder			Thyroid disease	
	Colon polyps							

Other medical problems:

____

____

Have you had any recent hospitalizations or ER visits (provide dates and reason below)?

Date:	Reason:	Date:	Reason:

SURGICAL HISTORY

List all prior surgeries and the date. ❑ No prior surgeries

Date:	Type of Surgery	Date:	Type of Surgery

Have you had any difficulty with anesthesia? ❑ Yes ❑ No If yes, explain: ______________________

Have you received any blood transfusions in the past? ❑ Yes ❑ No Any problems? ❑ Yes ❑ No

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FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Mother				
Father				
Sister				
Brother				
Daughter				
Son				

Does anyone in your family have a history of colon cancer, colon polyps or liver disease? ❑ Yes ❑ No If yes, explain:

____

SOCIAL HISTORY

Occupation ____ Employer ____

Exercise? No ____ Yes ____ Type(s) ____ Hours per Week ___________

Do you have advance directives? ____

Do you have any religious belief that could affect your medical care? ____

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

Tobacco/smoking status: Never _____

Current _____ Type _______________ Amount _______________ Duration _________________

Former _____ Type _______________ Amount _______________ Duration _________________

Do you use alcohol? No _____ Yes _____ Type __________ Amount _______________ Frequency _______________

Do you use Caffeine? No _____ Yes _____ Type __________ Amount _______________ Frequency _______________

Do you use recreational drugs? No _____ Yes _____ Type ___________ Amount ___________ Frequency _____________

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REVIEW OF SYSTEMS

In the last **thirty days,** have you experienced any of the following:

CONSTITUTIONAL			GASTROINTESTINAL			ENDOCRINE		
Fever	Yes	No	Abdominal pain	Yes	No	Excessive thirst	Yes	No
Fatigue	Yes	No	Black tarry stools	Yes	No	Heat or cold intolerance	Yes	No
Good general health	Yes	No	Bloating gas	Yes	No	**MUSCULOSKELETAL**		
Recent weight loss	Yes	No	Constipation	Yes	No	Joint pain	Yes	No
HEENT			Diarrhea	Yes	No	Muscle pain/cramps	Yes	No
Blurred/Double vision	Yes	No	Heartburn or reflux	Yes	No	**SKIN**		
Mouth sores	Yes	No	Hemorrhoids	Yes	No	Bad breath/taste	Yes	No
Ringing in the ears	Yes	No	Jaundice	Yes	No	Bleeding gums	Yes	No
Trouble swallowing	Yes	No	Loss of appetite	Yes	No	Voice change	Yes	No
RESPIRATORY			Nausea	Yes	No	**NEUROLOGICAL**		
Frequent coughing	Yes	No	Vomiting	Yes	No	Frequent or recurring headaches	Yes	No
Shortness of breath	Yes	No	Ulcers, GI bleeding	Yes	No	Light headed or dizzy	Yes	No
CARDIOVASCULAR			Hepatitis Type: ______________________	Yes	No			
Chest pain	Yes	No	**GENITOURINARY**					
Swelling of feet/ankles/hands	Yes	No	Frequent urination	Yes	No			
			Incontinence or dribbling	Yes	No			
			HEMATOLOGIC					
			Easily bruise/bleed	Yes	No			

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