Florida Digestive Health Specialists

Patient History Form

MR#		
Last Name	First Name, Middle Initial	Date of Birth

Primary Care Physician	Other doctors involved in your care:

PLEASE DO NOT WRITE IN THE BOX BELOW. FOR OFFICE STAFF ONLY

Nurses / Doctors notes:
Tests or labs ordered today:

WHAT IS THE REASON FOR YOUR VISIT WITH US TODAY?

Chief Complaint:

HAVE YOU HAD OR BEEN DIAGNOSED WITH ANY OF THESE ISSUES IN THE PAST?

System	*Yes*	*No*	*Year*	*System*	*Yes*	*No*	*Year*	*System*	*Yes*	*No*	*Year*
CARDIAC				***NEUROLOGIC***				***EAR, NOSE, THROAT***			
High blood pressure				Seizures				Loose teeth			
Low blood pressure				Weakness				Nosebleeds			
Irregular heartbeat				Migraines				Deafness			
Chest pain				Previous stroke				***PSYCHOSOCIAL***			
High cholesterol				***MUSCULOSKELETAL***				Alcoholism			
Vascular disease				Muscle disease				Substance abuse			
Pacemaker											
RESPIRATORY				Arthritis				Depression			
Asthma				Neck pain				Anxiety disorders			
Pneumonia				Back pain							
Bronchitis				Blood disorder							
Chronic cough				**Type of blood disorder:**				**Please list below any other symptoms:**			
Hoarseness											
Tracheostomy											
COPD				Rash							
Tuberculosis				MRSA							
GENITOURINARY				Bruises							
Kidney disease				***OPHTHALMIC***							
Chronic renal failure				Blindness				***Diagnosed with Cancer? Please list:***			
Currently on dialysis				Cataracts							
Urine infection (UTI)				Glaucoma							
ENDOCRINE/METABOLIC				***BREAST***							

Diabetes TYPE I / TYPE II				Lumps							
Thyroid disorder				Cancer							

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HAVE YOU EXPERIENCED ANY OF THE FOLLOWING GASTROINTESTINAL AND HEPATIC SYMPTOMS RECENTLY?

System	***TODAY***	***In the past 2 months***	***PLEASE INDICATE IF THIS ISSUE HAS BEEN RESOLVED BY WRITING "RESOLVED," or you may explain.***
GASTROINTESTINAL			
Diarrhea			
Constipation			
Rectal bleeding			
Change in bowel habits			
Weight loss			
Dark stools			
Irritable bowel			
Crohn's disease			
Ulcerative colitis			
Trouble swallowing			
Nausea/Vomiting			
Heartburn			
Abdominal pain			
HEPATIC			
End-stage liver disease			
Cirrhosis			
Hepatitis			
Pancreatitis ACUTE/CHRONIC			

PAST GASTROINTESTINAL PROCEDURES:	**YES**	**NO**	**APPROXIMATE DATE OF PROCEDURE**	**WERE POLYPS FOUND?**	**ANY ABNORMAL FINDINGS PLEASE EXPLAIN:**
HAVE YOU HAD A COLONOSCOPY IN THE PAST?					
HAVE YOU HAD AN UPPER ENDOSCOPY (EGD)?					
Have you:	**YES**	**NO**	**APPROXIMATE DATE(s)**		
Had a blood transfusion?					
Donated blood?					
Do you have tattoos (year of oldest tattoo)					

Have you ever had any surgery or been hospitalized?____Yes ___No Problems with anesthesia?___Yes___No If yes, please list:	Surgeries	Dates	Hospitalizations other than surgery	Dates
Social History:	Alcohol: How many drinks per day?_______Per week?_______Per month?_______ Do you currently use street drugs____Yes_____No If yes, How often? ____________ Have you ever used street drugs______Yes____No When did you quit?____________			
Tobacco use: Please check one: Non-Smoker: _________ Current smoker________ Former Smoker________	Tobacco: How many packs per day?__For how many years?_______ At what age did you begin Smoking?_____________Year quit _____________			

Please list any allergies, including environmental, medication, food, and reaction to previous blood transfusion.	

FAMILY HISTORY **Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:**

Condition	*Relation*	*Living/Deceased?*	*Condition*	*Relation*	*Living/Deceased?*	*Condition*	*Relation*	*Living/Deceased?*
Colon/ Rectal Cancer No____Yes_____			Kidney problems No____Yes_____			Heart disease No____Yes____		
Stomach cancer No____Yes_____			Ulcerative colitis No____Yes____			Crohn's disease No____Yes____		
Breast cancer No____Yes_____			Ovarian cancer No____Yes_____			Bleeding problems No____Yes____		

Please indicate in this section any issues we have not addressed on this form:

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*****Patients: please do not sign until the Medical Assistant has gone over this information with you*****

I______________________________agree that the information I have provided on this patient
Printed Patient Name
history form is accurate to the best of my knowledge. The Medical Assistant has reviewed the information with me in the room, and I agree that this information will become part of my permanent medical record.

____ ____________________
Patient Signature Today's date

FOR OFFICE USE ONLY, PATIENTS PLEASE DO NOT WRITE BELOW THIS LINE

The above information has been reviewed and discussed with the patient **YES / NO**	Date reviewed	Staff name/Title	Signature
Patient refused**: YES / NO** **If Refused, Reason:**			

F02-6/24/2020