CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Complete Patient History Form

Name:_____Date of Birth:_____

The following information is **very important to your health**. Please take time to fully and completely fill out this important information. We are counting on you!

o **Reason for visit**_____

_____

Race

o White/Caucasian	o Black or African American	o Asian	o Hispanic or Latino
o American Indian or Alaska Native	o Native Hawaiian or Other Pacific Islander	o Mixed	o Other
o Unknown	o Patient Declines to provide information		

Ethnicity

o Hispanic or Latino	o Not Hispanic or Latino	o Patient Declines to provide information

Gender

o Male	o Female	o Other

Preferred Language

o English	o Spanish	o Other_____

Contact Preference

o Letter	o Other_____

o **What pharmacy do you want us to use for any medications that are prescribed?**

Pharmacy: _____

_____

Allergies

o Patient has no known allergies	o Patient has no known **DRUG** allergies	o Adhesive tape	o Codeine Sulfate
o Erythromycin	o Latex	o IV Contrast	o Penicillins
o Sulfa	o Shellfish	o Other_____	o Other_____

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Current Medications

o None

Name Dose How taken

_____

_____

_____

_____

_____

_____

_____

_____

_____

Immunizations

o None	o Flu vaccine When:_____	o Hepatitis A When:_____
o Hepatitis B When:_____	o Pneumovax When:_____	o TB Skin test When:_____

Diagnostic Studies

o None	o Colonoscopy When:_____	o Endoscopy/EGD When:_____
o CT Scan Abdomen/Pelvis When:_____	o MRI of Abdomen/Pelvis When:_____	o ERCP When:_____

Previous Procedures/Surgeries

o None	o Gallbladder removed	o Appendectomy	o Colon resection	o Small Bowel resection
o Exploratory Abdominal Surgery	o Gastric Bypass Surgery	o Lap Band Surgery	o Hemorrhoid Surgery	o Hemorrhoid Banding
o Abdominoplasty	o Hysterectomy	o Tubal Ligation	o Mastectomy	o Pacemaker Placement
o Defibrillator Placement	o Coronary Artery Bypass Graphing (CABG)	o Abdominal Aortic Aneurysm (AAA) Repair	o Heart Valve Replacement /Surgery	o Cardiac Catherization /Stent
o Joint Replacement	o Back Surgery	Other_____	Other _____	

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Past or Present Medical History

- **Gastroenterology/Hepatology**

o Colon polyps	o Colon cancer	o Irritable Bowel Syndrome	o Diverticulitis
o Crohn's Disease	o Ulcerative Colitis	o GERD /Reflux	o Barrett's Esophagus
o Ulcer Disease	o Hepatitis B	o Hepatitis C	o Fatty Liver Disease
o Cirrhosis/Liver	o Celiac Disease	o Bowel Obstruction	o Pancreatitis
o Anemia in the past	o Other _____	o Other _____	o Other _____

- **Cardiology**

o Coronary Heart Disease	o Heart Valve Disease	o Congestive Heart Failure	o Heart attack
o High Blood Pressure	o Atrial Fibrillation	o Vascular Disease	o High Cholesterol
o Stroke	o TIA (mini stroke)	o Other _____	

- **Pulmonary**

o C.O.P.D.	o Asthma	o Sleep Apnea
o Blood Clots (leg)	o Blood Clots (lung)	

- **Other**

o Anxiety Disorder	o Arthritis	o Bipolar Disorder	o Body Piercings
o Breast Cancer	o Current Pregnancy	o Depression	o Diabetes
o Fibromyalgia	o Gout	o HIV Exposure	o HIV Infection
o Hypothyroidism	o Kidney Disease	o Kidney Stones	o Lung Cancer
o Ovarian Cancer	o Other Cancer	o Prostate Cancer	o Recurrent Infections
o Seizures	o Skin Cancer	o Tattoos	Other_____

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Social History

o Single	o Married	o Divorced	o Separated
o Widowed	o Civil Union	o Unknown	o Other

I drink alcohol:	**I drink caffeine:**	**I use tobacco:**	**My drug use:**	**I exercise:**
____None _____Less than 7 per week _____More than 7 per week	(coffee, tea, cola, or other caffeinated drinks) _____None _____Occasionally _____Daily	(Circle) Cigarettes Cigars Chewing tobacco __Every Day __Only some days __Former smoker __Never smoked __Smoker, Current status unknown __Unknown if ever smoked	_____None _____Recreational drugs **currently** _____ Recreational drugs **in the past**	___None ___I exercise routinely

Family History

o No knowledge of family history

o **No one in my family has a history of**:

o Celiac Sprue	o Colon polyps	o Gallbladder Disease
o Liver Disease	o Stomach Cancer	o Colon Cancer
o Crohn's Disease	o Inflammatory Bowel Disease	o Polyps
o Ulcerative Colitis		

o **Someone in my family has a history of:** (please check all that apply)

	Mother	**Father**	**Sister**	**Brother**	**Grandmother**	**Grandfather**
Colon Cancer						
Colon Polyps						
Crohn's Disease						
Gallbladder Disease						
Liver Disease						
Ulcerative Colitis						
Stomach Cancer						

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Review of Systems....What are your current symptoms today? (check all that apply):

Allergic/Immunologic
- allergic reactions ○
- current infections ○

Cardiovascular
- chest pain ○
- irregular heart beat ○
- rapid heart rate/palpitations ○
- ankle swelling ○

Constitutional
- fever ○
- loss of appetite ○
- weight loss ○

ENMT
- nose bleeds ○
- loss of vision ○
- hoarseness ○
- mouth sores ○

Endocrine
- excessive thirst ○
- heat or cold intolerance ○

Gastrointestinal
- abdominal pain ○
- abdominal swelling ○
- change in bowel habits ○
- constipation ○
- diarrhea ○
- gas ○
- heartburn ○
- nausea ○
- rectal bleeding ○
- stomach cramps ○
- vomiting ○
- difficulty swallowing ○
- yellowing of skin ○

Genitourinary
- blood in urine ○
- recent darkening of urine ○

Hematologic/Lymphatic
- easy bruising ○
- anemia ○

Integumentary
- itching ○
- rashes ○
- rashes/hives ○

Musculoskeletal
- back pain ○
- joint pain/arthritis ○

Neurological
- dizziness ○
- fainting ○
- frequent headaches ○
- vertigo ○
- memory loss/confusion ○

Psychiatric
- depression ○
- anxiety/panic attacks ○

Respiratory
- wheezing ○
- frequent cough ○
- shortness of breath when at rest ○