

DATE: \_\_\_\_\_ DOB: \_\_\_\_\_

NAME: \_\_\_\_\_ AGE \_\_\_\_\_ SEX: M / F PCP: \_\_\_\_\_

**CHIEF COMPLAINT:** \_\_\_\_\_

**ALLERGIES TO MEDICATIONS:**

**HISTORY OF PRESENT ILLNESS:**

(CGS Physician Comments Only)

Where is the pain / problem? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How often does it occur? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When did this begin? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Was there a situation that surrounded the onset of the problem?

\_\_\_\_\_  
\_\_\_\_\_

Describe the characteristics of the pain / problem. (Normal or abnormal, feels like?) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

At this time how would you describe the severity of the pain / problem? Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

At this time how would you describe the severity of the pain / problem? (Ex. Bloating, gas, constipation, diarrhea, fever, etc.)

\_\_\_\_\_  
\_\_\_\_\_

What makes the symptom better \_\_\_\_\_ or worse \_\_\_\_\_? (Ex. Eating, passing a BM, position, movement, urination)

\_\_\_\_\_  
\_\_\_\_\_

**DIGESTIVE SYSTEM:**

Do you have or have you ever been told you have:

- | Yes                      | No                       |                      |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Reflux or GERD       |
| <input type="checkbox"/> | <input type="checkbox"/> | Esophageal stricture |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcers       |
| <input type="checkbox"/> | <input type="checkbox"/> | Hiatal Hernia        |
| <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Pancreas problems    |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver problems       |
| <input type="checkbox"/> | <input type="checkbox"/> | Diverticulosis       |

**DIGESTIVE SYSTEM:**

Do you have or have you ever been told you have:

- | Yes                      | No                       |                                     |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diverticulitis                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Inflammation of the colon / colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Colon polyp                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Colon cancer                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Anal fissures                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Anal fistula                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Other GI diseases not mentioned     |

Comments: \_\_\_\_\_

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History Form  
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Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Are you having problems with?**

<p align="center"><b>Constitutional</b></p> <p>Yes      No</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Loss of appetite</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Weight loss</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Increased fatigue</p>			<p align="center"><b>Mouth-Esophageal</b></p> <p>Yes      No</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Sore throat / burning</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Difficulty swallowing pills or food</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Difficulty swallowing liquids</p>		
<p align="center"><b>Chest</b></p> <p>Yes      No</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Heartburn</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Indigestion</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Chest pain</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Belching</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Regurgitation of foods or liquids</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Chest / Abdominal Pain awakens you at night</p>			<p align="center"><b>Abdomen</b></p> <p>Yes      No</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Nausea</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Vomiting</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Abdominal pain</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Abdominal pain associated with meals</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Abdominal fullness after eating only small amounts</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Bloating</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Milk / Lactose intolerance</p>		
<p align="center"><b>Bowel Habits</b></p> <p>Yes      No</p> <p><input type="checkbox"/>    <input type="checkbox"/>    A change in your bowel habits</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Constipation</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Diarrhea</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Alternate between constipation and diarrhea</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Feeling of bowels not emptying completely</p> <p><input type="checkbox"/>    <input type="checkbox"/>    A sense of urgency to empty your bowels</p>			<p align="center"><b>Colon / Rectal</b></p> <p>Yes      No</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Abdominal pain in lower abdomen</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Rectal pain</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Rectal bleeding</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Black or tarry looking stools</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Mucus or pus in the stools</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Abdominal pain relieved by a BM</p> <p><input type="checkbox"/>    <input type="checkbox"/>    Increased rectal gas</p>		

Comments: \_\_\_\_\_

Have you been seen by a Gastroenterologist before?    Yes    \_\_\_\_\_    No    \_\_\_\_\_    Procedures Performed?    \_\_\_\_\_

Name of MD: \_\_\_\_\_ Dates: \_\_\_\_\_

**MEDICATIONS:**

(Please list all present medications, non-prescription / over the counter meds and herbs taken on a daily basis or as needed. Record the name, dosage, and how many times a day they are taken. Please include fiber supplements, laxatives, antacids, and vitamins.)

- |          |           |
|----------|-----------|
| 1. _____ | 7. _____  |
| 2. _____ | 8. _____  |
| 3. _____ | 9. _____  |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Do you have or have you ever had:

**Constitutional**

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Fever or chills                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems sleeping/sleep apnea/nasal C-Pap |

**Endocrine**

- | Yes                      | No                       |                 |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes        |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast lumps    |

**Respiratory**

- | Yes                      | No                       |                           |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough             |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood         |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease              |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis              |
| <input type="checkbox"/> | <input type="checkbox"/> | Positive skin test for TB |

**Genitourinary**

- | Yes                      | No                       |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems (male)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Get up at night to urinate |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination          |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones              |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease             |

**Skin**

- | Yes                      | No                       |                             |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in skin color       |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormalities of the skin   |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual itching of the skin |

**Musculoskeletal**

- | Yes                      | No                       |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck or back pain          |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pain                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement          |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle aches or tenderness |

**Psychiatric**

- | Yes                      | No                       |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with anxiety      |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Other psychiatric problems |

**Eye, Ear, Nose, Throat, Mouth**

- | Yes                      | No                       |                          |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye injuries or diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear Diseases             |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems           |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic sore throat      |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth ulcers             |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds               |

**Cardiovascular**

- | Yes                      | No                       |                                    |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath                |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells or blackout spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of the feet or ankles     |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain or tightness            |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure                |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valve             |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood thinners                     |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol                   |

**Gynecological**

- | Yes                      | No                       |                   |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Painful periods   |
| <input type="checkbox"/> | <input type="checkbox"/> | Regular periods   |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge or pain |

Date of last pelvic exam \_\_\_\_\_

Date of onset of menopause \_\_\_\_\_

Number of pregnancies \_\_\_\_\_

**Hematology / Lymphatic**

- | Yes                      | No                       |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Lymph node enlargement |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding problems      |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion      |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                 |

**Neurological**

- | Yes                      | No                       |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures           |

Comments: \_\_\_\_\_

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PREVIOUS HOSPITALIZATIONS AND SURGICAL PROCEDURES:**

Date	Where	Type of surgery and reason / Hospital admission and reason	Physician
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

**IMMEDIATE FAMILY:** (please list all siblings and/or other children)

	Age	Age at Death	Medical Problems
Mother	_____	_____	_____
Father	_____	_____	_____
Sisters	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
Brothers	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
Children	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
	4. _____	_____	_____

**FAMILY HISTORY:**

Has anyone in your immediate family ever had?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic disease	<input type="checkbox"/>	<input type="checkbox"/>	(Peptic) ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	Other digestive diseases	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Other colitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Any other diseases run in several family members

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL HISTORY:**

Please check all that apply:

Married     Single     Widowed     Divorced     Separated (Number of years \_\_\_\_\_)

Current job: (if retired, previous occupation) \_\_\_\_\_

Education Level: (check highest level of school completed)

Grade     Middle     High     College     Tech/Trade

Stress Level:     Low     Average     High

Have you ever lived or traveled outside the United States:     Yes     No    Where? \_\_\_\_\_

Any illness associated with travel?     Yes     No    What? \_\_\_\_\_

Exercise?     None     Occasionally     Regularly

Tobacco Use:

Never Smoked     Quit    How long ago? \_\_\_\_\_

Cigarettes     Cigar     Pipe     Snuff     Chewing tobacco    How much per day? \_\_\_\_\_

Alcohol Use:

Never used alcohol     Quit    How long ago? \_\_\_\_\_

Beer     Wine     Liquor     Other \_\_\_\_\_    How much per day? \_\_\_\_\_    How many years? \_\_\_\_\_

Illegal Drugs:

Never use (other than prescription)     Quit    How long? \_\_\_\_\_     Marijuana

Cocaine     IV drugs \_\_\_\_\_     Other \_\_\_\_\_    How much per day? \_\_\_\_\_    How many years? \_\_\_\_\_

Caffeine:

Never use caffeine     Quit    How long? \_\_\_\_\_

Coffee     Tea     Soda     Other \_\_\_\_\_    How much per day? \_\_\_\_\_