CONNECTICUT GI

HEALTH HISTORY

Date:_____

Patient Name_____ D.O.B.:_____

Do you require an interpreter? ☐ Yes ☐ No If yes, what language?_____

Do you have any mobility limitations? *Please select all that apply* ☐ NONE ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair

Do you have any visual limitations? ☐ NONE ☐ Glasses ☐ Contacts ☐ Glaucoma ☐ Blind

Do you have any auditory limitations? ☐ NONE ☐ Decreased Hearing ☐ Hearing Aids-Left and/or Right ☐ Deaf

Do you wear dentures? ☐ NONE ☐ Upper ☐ Lower ☐ Partial ☐ Braces

Are you pregnant? ☐ Yes ☐ No

Date of last menstrual period:_____

REFERRING PHYSICIAN

Name:_____

Primary care physician? ☐ Yes ☐ No

OTHER PROVIDERS

Primary Care Physician:_____

Do you have a cardiologist? ☐ Yes ☐ No If yes, who is your cardiologist?_____

If yes to cardiologist, when was your last visit?_____

CURRENTLY ACTIVE SYMPTOMS AND OTHER CONDITIONS

Current Height:_____ Current Weight:_____

Select any of these symptoms or conditions you CURRENTLY have.

General	☐ Antibiotic Treatment within last 3 days	☐ Decreased Appetite	☐ Fever	
	☐ Malaise/Fatigue	☐ Night Sweats	☐ Weight Loss	☐ NONE
Skin	☐ Itching	☐ Rash	☐ Jaundice/Yellowing of Skin	☐ NONE
HENT	☐ Hearing Loss	☐ Hoarseness	☐ Sleep Apnea	☐ NONE
Eyes	☐ Glaucoma	☐ Wears Glasses/Contacts	☐ NONE	
Cardiovascular	☐ Chest Pain	☐ Feet Swelling	☐ Hand Swelling	☐ Increased Blood Pressure
	☐ Leg Cramps	☐ Palpitations	☐ Fainting	☐ NONE
Respiratory	☐ Cough	☐ Difficulty Breathing	☐ Wheezing	☐ Shortness of Breath
GU	☐ Blood in Urine	☐ Change in Urine Output	☐ Frequency	☐ Painful Urination
	☐ Pelvic Pain	☐ NONE		
Breast	☐ Breast Mass	☐ Breast Pain	☐ NONE	
GI	☐ Abdominal Pain	☐ Abdominal Swelling	☐ Belching	☐ Black Stool
	☐ Bloating	☐ Blood in Stool	☐ Change in Bowel Habits	☐ Constipation
	☐ Diarrhea	☐ Difficulty Eating/Swallowing	☐ Food Intolerance	☐ Gas/Flatulence
	☐ Get Full Quickly at Meals	☐ Heartburn	☐ Laxative Use	☐ Nausea
	☐ Painful Bowel Movements	☐ Painful Swallowing	☐ Vomiting	☐ Vomiting Blood ☐ NONE
Musculoskeletal	☐ Back Pain	☐ Joint Pain	☐ Physical Disability	☐ NONE
Neurological	☐ Difficulty with Speech	☐ Dizziness	☐ Fainting	☐ General Weakness
	☐ LOC	☐ Seizures	☐ NONE	
Psychiatric	☐ Depression	☐ Nervous/Anxious	☐ Suicidal Ideas	☐ NONE
Endo/Heme/ Allergies	☐ Easily Bruise/Bleed	☐ Excessive Thirst	☐ Excessive Urination	☐ Cold Intolerance
	☐ Heat Intolerance	☐ NONE		

MEDICATIONS

☐ I am not taking any medications, vitamins or supplements.

Please list all medications you are currently taking.

Medication_______________ Dosage__________ Frequency__________

Reason_______________

Medication_______________ Dosage__________ Frequency__________

Reason_______________

Medication_______________ Dosage__________ Frequency__________

Reason_______________

Medication_______________ Dosage__________ Frequency__________

Reason_______________

Medication_______________ Dosage__________ Frequency__________

Reason_______________

Medication_______________ Dosage__________ Frequency__________

Reason_______________

Medication_______________ Dosage__________ Frequency__________

Reason_______________

ALLERGIES

Drug: ☐ NONE ☐ General Anesthetic ☐ Local Anesthetic ☐ Carbamazepine ☐ Codeine ☐ Iodine ☐ Insulin preparations ☐ NSAIDs ☐ Penicillin ☐ Phenytoin ☐ Sulfa drugs ☐ Tetracycline

Food: ☐ NONE ☐ Peanuts ☐ Eggs ☐ Seafood ☐ Wheat ☐ Shellfish ☐ Corn ☐ Dairy ☐ Soy

Environmental: ☐ NONE ☐ Animals ☐ Dust mites ☐ Latex ☐ Stinging insects ☐ Mold ☐ Wool ☐ Plant pollens (Hay Fever)

Other Allergies: *If any, please list reaction.*

1.__________ Reaction__________

2.__________ Reaction__________

3.__________ Reaction__________

4.__________ Reaction__________

5.__________ Reaction__________

6.__________ Reaction__________

7.__________ Reaction__________

Have you or any family member had any problems with Anesthesia? ☐ Yes ☐ No If yes, please explain:

____

Have you ever been told that you were difficult to intubate? ☐ Yes ☐ No

SURGERIES

Please select all surgeries you have had. If you have not had any surgeries, please select NONE.

☐ NONE
☐ Amputation
☐ Aneurysm Repair
☐ Angioplasty
☐ Aortic Valve Replacement
☐ Appendectomy
☐ AV Graft/Fistula
☐ Back Surgery
☐ Brain Surgery
☐ Breast Surgery
☐ Cardiac Catheterization
☐ Cardiac Stents
☐ Carotid Endarterectomy
☐ Carpal Tunnel Release
☐ Cataract Removal/IOL Implant
☐ Cesarean Section
☐ Colon Surgery
☐ Coronary Artery Bypass Graft
☐ Defibrillator
☐ Dialysis Catheter
☐ Gall Bladder
☐ Hernia Repair
☐ Hip Replacement
☐ Hysterectomy
☐ Kidney Transplant
☐ Knee Arthroscopy
☐ Knee Replacement
☐ Liver Transplant
☐ Lumpectomy
☐ Lysis of Adhesions
☐ Mastectomy
☐ Obstructive Sleep Apnea
☐ Pacemaker
☐ Prostate Surgery
☐ Shoulder Surgery
☐ Stomach Surgery
☐ Thyroidectomy
☐ Tonsillectomy
☐ Valve Replacement
☐ Weight Loss

PREVIOUS GI PROCEDURES

☐ Colonoscopy in past:_____

☐ Upper endoscopy in past:_____

☐ Other:_____

PATIENT MEDICAL HISTORY *Please select from the list below if you have had any of the conditions listed below or select NONE.*

Cardiovascular

☐ NONE
☐ Aneurysm
☐ Angina
☐ Atrial Fibrillation
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Hardened Arteries
☐ Heart Attack
☐ High Cholesterol
☐ Hypertension
☐ Peripheral Vascular Disease
☐ Rheumatic Fever

Non-Gastrointestinal Conditions

☐ NONE
☐ Arthritis
☐ Fibromyalgia
☐ Gout
☐ HIV/AIDS
☐ Lupus
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Rheumatoid Arthritis

Cancer

☐ NONE
☐ Breast Cancer
☐ Colon Cancer
☐ Esophageal Cancer
☐ Leukemia
☐ Liver Cancer
☐ Lung Cancer
☐ Oral Cancer
☐ Ovarian
☐ Pancreatic Cancer
☐ Prostate Disease
☐ Rectal Cancer
☐ Skin Cancer
☐ Stomach Cancer
☐ Thyroid Cancer
☐ Uterine

Respiratory

☐ NONE
☐ Asthma
☐ Chronic Bronchitis
☐ Chronic Cough
☐ COPD
☐ CPAP Dependence
☐ Oxygen at Home
☐ Pneumonia
☐ Sleep Apnea
☐ Tuberculosis

Gastrointestinal

☐ NONE
☐ Anal Fissure
☐ Barrett's Esophagus
☐ Celiac Disease
☐ Colon Polyps
☐ Constipation
☐ Crohn's Disease
☐ Diverticulitis/Diverticulosis
☐ Dysphagia
☐ Esophageal Stricture or Narrowing
☐ Food Intolerance
☐ GERD
☐ H. Pylori Infection
☐ Heartburn
☐ Hemorrhoids
☐ Hiatal Hernia
☐ Incontinence of Stool
☐ Intestinal Infection/C. Diff
☐ Irritable Bowel Syndrome
☐ Odynophagia
☐ Pancreatitis
☐ Peptic Ulcer
☐ Ulcerative Colitis

Hepatic

☐ NONE
☐ Ascites
☐ Cirrhosis
☐ Elevated Enzymes
☐ Esophageal Varices
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

Endocrine

☐ NONE
☐ Diabetes Mellitus
☐ Thyroid Disease

Renal/Genitourinary

☐ NONE
☐ Dialysis
☐ Dysuria
☐ Hematuria
☐ Kidney Stones
☐ Renal Failure
☐ Renal Insufficiency
☐ UTI

Blood/Heme

☐ NONE
☐ Anemia
☐ Anticoagulation/Blood Thinner
☐ Clotting Disorder
☐ DVT/PE
☐ History of Blood Transfusion
☐ Sickle Cell Anemia

Neurological

☐ NONE
☐ Migraine, Common
☐ Paralysis
☐ Parkinson's Disease
☐ Seizures
☐ Stroke

Breast

☐ NONE
☐ Breast Mass

FAMILY HISTORY

RELATIONSHIP	No Known Problems	Alcohol Abuse	Autoimmune Disease	Bleeding Disorder	Blood Clots	Breast Cancer	Cancer, Other	Celiac Disease	Cholelithiasis	Cirrhosis	Colon Cancer	Colon Polyps	Crohn's Disease	Diabetes	Esophageal Cancer	Heart Attack	Hemochromatosis	Hepatitis	Hypertension	Irritable Bowel Synd.	Liver Cancer	Liver Disease	Mental Illness	Ovarian Cancer	Pancreatitis	Prostate Cancer	Sickle Cell Anemia	Stomach Cancer	Stroke	Tuberculosis	Ulcerative Colitis	Ulcers	Uterine Cancer
Mother																																	
Father																																	
Sister																																	
Brother																																	
Maternal Aunt																																	
Maternal Uncle																																	
Paternal Aunt																																	
Paternal Uncle																																	
Maternal G. Mother																																	
Maternal G. Father																																	
Paternal G. Mother																																	
Paternal G. Father																																	
Other																																	

PERSONAL AND SOCIAL HISTORY

Do you live alone? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

How many times per week do you exercise?_____

Type of exercise?_____

Do you consume alcohol? ☐ Yes ☐ No

What type of alcohol do you drink?_____

Average number of drinks per week (now or in the past)?_____

Have you felt a need to cut down on alcohol? ☐ Yes ☐ No

What is your smoking status? ☐ Never Smoked ☐ Former Smoker ☐ Current every day smoker

How many years total have you smoked?_____

How many packs?_____ per_____

Do you use smokeless Tobacco? ☐ Current ☐ Former ☐ Never

Daily use of smokeless tobacco?_____

How many years total have you used smokeless tobacco?_____

Have you ever been exposed to 2nd hand smoke? ☐ Yes ☐ No

IV drug use or other recreational drug use? ☐ Yes ☐ No

Drug of choice? ☐ Marijuana ☐ Cocaine ☐ Crack ☐ Heroin ☐ Illicit Rx ☐ Other_____

Have you engaged in high risk behavior for HIV or other STD's? ☐ Yes ☐ No

If you drink Caffeine, how many drinks per day? ☐ 0 /day ☐ <1 /day ☐ 1 /day ☐ 2 /day ☐ 3 /day ☐ 4 /day ☐ 4+ /day

Do any males in your family have a history of heart attacks or sudden death under the age of 55? ☐ Yes ☐ No

Do any females in your family have a history of heart attacks or sudden death under the age of 65? ☐ Yes ☐ No

Have you ever had a Blood Transfusion? ☐ Yes ☐ No

Have you had any recent Foreign Travel? ☐ Yes ☐ No

Do you have any Body Piercings? ☐ Yes ☐ No

Do you have any Tattoos? ☐ Yes ☐ No

How often do you wear a seat belt when in a car? ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

How much sun exposure do you get? ☐ frequently ☐ occasionally ☐ rarely ☐ remote

Use this space below to give us additional information you would like us to know regarding your health history or medications:

_____

_____