

MID-FLORIDA GASTROENTEROLOGY GROUP, P.A.

DATE: _____ PATIENT: _____ DOB: _____ ACCT: _____

MEDICAL HISTORY

Have you or the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/illnesses that you have checked below? Yes No

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Gastrointestinal			Cardiac			Neurologic			Ear, Nose, & Throat		
Diarrhea			High blood pressure			Seizures			Loose Teeth		
Constipation			Low blood pressure			Weakness			Nosebleeds		
Rectal Bleeding			Irregular heartbeat			Migraines			Deafness		
Change in BM's			Chest pain			Previous stroke			Psychosocial		
Weight loss			Respiratory			Musculoskeletal			Alcoholism		
Heartburn			Asthma			Muscle Disease			Substance Abuse		
Trouble swallowing			Pneumonia			Arthritis			Depression		
Nausea			Bronchitis			Neck pain			Anxiety disorders		
Vomiting			Chronic Cough			Back pain			Breast		
Abdominal Pain			Hoarseness			Blood Disorders			Lumps		
Polyps			Tracheostomy			Skin			Cancer		
Irritable Bowel			Genitourinary			Rash			Any symptoms/diseases		
Hepatic			Kidney Disease			Bruises			not listed above?		
Liver Disease			Frequent urine infection			Ophthalmic			Please list below:		
Yellow Skin			Endocrine/Metabolic			Cataracts					
Hepatitis			Diabetes			Glaucoma					
Pancreatitis			Thyroid Disorders			Blindness					

HISTORY

Please explain any YES answers in detailed description in the box provided.

Have you ever had any surgery or been Hospitalized? Have you had any problems with anesthesia? No ___ Yes ___ If yes, please list below:	<input type="checkbox"/> No	Surgeries	Dates	Hospitalizations other than surgery	Dates		
	<input type="checkbox"/> Yes						
Are you currently or have you ever used any Tobacco or alcohol products?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Alcohol: How many drinks <input type="checkbox"/> per day ___ <input type="checkbox"/> per week ___ <input type="checkbox"/> per month ___ Tobacco: How many packs per day <input type="checkbox"/> For how many years? ___					
Are you or have you ever used recreational /illicit drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, what kind? For how long?					
Are you currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Medication	Dose	Times	Medication	Dose	Times
Do you have any allergies (including environmental, medication, food, and reaction to previous blood transfusion)?	<input type="checkbox"/> No <input type="checkbox"/> Yes						

FAMILY HISTORY

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

Condition	Relation to patient	Condition	Relation to patient	Condition	Relation to patient
Colon/ Rectal Cancer No ___ Yes ___		Colon Polyps No ___ Yes ___		Heart Disease No ___ Yes ___	
Colon/Rectal Cancer No ___ Yes ___		Ulcerative Colitis No ___ Yes ___		Crohn's Disease No ___ Yes ___	
Breast Cancer No ___ Yes ___		Ovarian Cancer No ___ Yes ___		Uterine Cancer No ___ Yes ___	
Stomach Cancer No ___ Yes ___		Pancreatic Cancer No ___ Yes ___		Bleeding Problems No ___ Yes ___	

Person Completing This Form/Relationship to Patient _____

Reviewed by Provider _____

Date(s) _____