

Patient Medical History Form

N.B. EDGERTON, Jr., M.D.

Gastroenterology

Patient Name : _____

Date of Birth: _____ Age: _____ Sex: _____

Have you ever had: (check all that apply)

Cataracts	Heart Attack/Angina	Pleurisy	Kidney Stone	German Measles	
Glaucoma	Heart Disease	Jaundice/ Liver Disease	Diabetes	Rheumatic Fever	
Asthma	Heart Murmur	Ulcers	Thyroid Disease	Chicken Pox	
Allergies	High Blood Pressure	Digestive Disorder	Anemia	Syphilis	
Stroke	Pneumonia	Hemorrhoids	Bleeding Disorder	Depression	
Seizures/ Epilepsy	TB / Lung Disease	Kidney Disease	Bone/Joint Disease	Recurrent Infections	
Cancer (type)					
List any other chronic illnesses that you have had:					

Operations: (please list any surgery and approximate year)	
Year	Surgery

Hospitalizations: (other than operations)		
Date	Reasons	Hosp

Medications (incl. over the counter items such as, Vitamins, Supplements and Herbals)		

Name _____

Date _____

Reviewed by _____
(Physician signature)

List all medication allergies	Immunizations	Yes	Year

Social History

Marital status: (circle) S M D W		Occupation: (if retired, prev. occupation)	
Birthplace:		Hobbies:	
Routine exercise: (circle) no yes		What/How often:	
Are you under a lot of pressure at work or home? (circle) no yes			
Have you ever smoked? (circle) no yes Cigar Pipe Cigarettes		If yes: # year's	# cigarettes/day
Are you a regular smoker now? (circle) no yes If no, when did you quit?			
Caffeine: Do you drink (circle) coffee, caffeinated teas or sodas regularly? No yes #/day			
Do you drink alcohol (circle) no yes If yes, check the following:			
<input type="checkbox"/> Hard Liquor, 1-3 oz. /day		<input type="checkbox"/> Hard Liquor, over 3 oz. /day	
<input type="checkbox"/> Beer, 12 oz. /day		<input type="checkbox"/> Beer, 2 bot. /day	
		<input type="checkbox"/> Beer, 3 bot. or more/day	
<input type="checkbox"/> Wine, 1 glass/day		<input type="checkbox"/> Wine, 2 glasses/day	
		<input type="checkbox"/> Wine, 3 or more glasses/day	
<input type="checkbox"/> Hard Liquor, Beer, Wine - occasional use			
Have you ever used any of the following? No yes (circle) Marijuana LSD Cocaine Speed Other			
Transfusions: have you ever had a blood or plasma transfusion (circle) no yes			
Females only: are you pregnant, planning a pregnancy or nursing a child? (circle) no yes			

Family Medical History

Family member:	Age	Health	Age at death	If deceased, cause	Has any blood relative ever had	Yes	Relationship
Father					Alzheimer's		
Mother					Tuberculosis		
Brothers or sisters					Diabetes		
Spouse					Heart disease		
Children					Bleeding disease		
					Stroke		
					Seizures		
					Depression		
					Suicide		
					Mental disorder		
					Allergies		
					Asthma		
					Cancer (type)		

Name _____

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(Physician signature)

Review of Systems

Please indicate those problems that have been a recurrent problem or a recent significant change to you.
Explain "yes" answers.

Yes	No	General Constitutional Symptoms	Explanation
		Good general health lately	
		Recent significant weight change	
		Unusual fatigue or weakness	
		Fevers	
		Frequent headaches	
Eyes			
		Change in vision	
		Double vision	
		Glaucoma	
		Eye disease or injury	
Ears/Nose/Mouth/Throat			
		Do you wear hearing aids?	
		Recent change in hearing	
		Earaches or drainage	
		ringing in ears	
		Chronic sinus problems or runny nose	
		Nose bleeds	
		Bleeding gums	
		Bad breath or bad taste in mouth	
		Sore throat/hoarseness or voice change	
		Swollen glands	
		Difficulty swallowing	
Neck			
		Enlarged thyroid	
		Lump or swelling	
		Pain or stiffness	
Cardiovascular			
		Heart trouble	
		Chest pain or angina	
		Palpitations	
		Shortness of breath when walking or lying flat	
		Swelling of feet or ankles	
Respiratory			
		Chronic or frequent cough	
		Coughing up blood	
		Shortness of breath	
		Asthma or wheezing	
Gastrointestinal			
		Loss of appetite	
		Change in bowel movements	
		Nausea or vomiting	
		Frequent diarrhea	
		Painful bowel movement or constipation	
		Rectal bleeding or blood in stool	
		Stomach pains or heartburn	
		Black tarry stools	
Genitourinary			
		Frequent urination	
		Burning or pain when urinating	

Name _____

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(Physician signature)

Review of Systems (continued)

Please indicate those problems that have been a recurrent problem or a recent significant change to you.

Yes	No	Genitourinary (continued)	Explanation
		Blood in urine	
		Change in force or strain when urinating	
		Incontinence or dribbling of urine	
		Sexual difficulties	
		In men - testicular pain	
		In women	
		- irregular or painful periods	
		- date of last menstrual period	
		- if applicable, method of birth control	
		- if menopausal, since when	
		- # pregnancies # deliveries # miscarriages	
		- date of last Pap smear	
Musculoskeletal			
		Joint pain	
		joint stiffness/swelling or warmth	
		Weakness of muscles or joints	
		Muscle pain or recurrent cramps	
		Back pain	
		Cold hands? or feet	
		Difficulty in walking	
Skin/Breast			
		Rashes or itching	
		Changes in skin color or moles	
		Change in hair or nails	
		Varicose veins	
		Breast pain	
		Breast lump	
		Breast discharge or rash	
Neurological			
		Increasing or frequent headaches	
		Recurrent light-headedness or dizziness	
		Spasms or convulsions	
		Numbness or tingling sensations	
		Tremors	
		Paralysis	
		Stroke	
		Head injury	
Psychiatric			
		Memory loss or confusion	
		Nervousness	
		Depression	
		Insomnia	
Endocrine			
		Glandular or hormone problem	
		Cold or heat intolerance	
		Excessive thirst or urination	
		Excessive skin dryness	
		Change in hat or glove size	
Hematologic/lymphatic			
		Slow to heal after cuts	
		Bleeding or bruising tendency	
		Recurrent anemia	
		Swelling or tenderness/warmth of veins	

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