

MEDICAL HISTORY FORM

PATIENT NAME: _____ BIRTHDATE: _____ AGE: _____

Please complete the enclosed Medical History Form and bring with you for your appointment with:

On: _____ At: _____

Brandywine Office Jennersville Office Exton Office

Please fill out this form **COMPLETELY** to the best of your ability. These questions are a necessary part of your consultation and the answers are confidential. If you do not understand the question, leave the area blank.

Why are you seeing the doctor today? _____

PERSONAL/SOCIAL HISTORY

Marital Status: Single/Married/Divorced/Separated/Widowed

Occupation: _____ Employer: _____

PERSONAL HABITS

Do you drink:

Coffee? Yes/No _____ cups /day
Tea? Yes/No _____ cups/day
Caffeinated soda? Yes/No _____ cans or bottles/day
Alcohol? Yes/No _____ drinks/week

Do you:

Smoke cigarettes? Yes/No _____ packs/day for _____ years
Chew tobacco? Yes/No _____ Do you have any tattoos? Yes/No
Do you currently use any street/recreational drugs? Yes/No which ones? _____
Have you ever used any street/recreational drugs? Yes/No which ones? _____
Are you on any type of special diet? Yes _____ No
List any drug allergies: _____
List any food or environmental allergies: _____
Do you take Aspirin, Ibuprofen (Motrin, Advil) Naproxen (Alleve, Naprosyn) Tylenol (Acetaminophen)
Ecotrin, Bufferin, Excedrin, Ascriptin Vitamins or Herbal Supplements
List any medications you take regularly: _____

PAST MEDICAL HISTORY

Have you ever had any of the following medical problems or procedures? Check all that apply.

Allergies _____	Heart Attack _____
Anemia _____	Heart Murmur _____
Anxiety _____	Heart Surgery _____
Arthritis _____	High Blood Pressure _____
Asthma _____	HIV/AIDS _____
Bronchitis _____	Kidney Disease _____
Chest Pain _____	Osteoporosis _____
Depression _____	Pneumonia _____
Diabetes _____	Seizures _____
Difficulty Sleeping _____	Skin Disorders _____
Emphysema _____	Stroke _____
Frequent urinary tract infections _____	Thyroid Disorders _____
Headaches _____	Vaginal Bleeding _____

Cancer site(s) _____ Treatment: surgery/chemotherapy/radiation therapy

Have you recently had pain in your stomach? Yes/No

Please check any of these that relate to your pain.

- _____ occurs 1-2 hrs after meals
- _____ brought on by eating greasy, fried foods
- _____ awakens you at night
- _____ is relieved temporarily by antacid medications
- _____ is relieved with milk or eating
- _____ occurs while eating or immediately after
- _____ is relieved by a bowel movement or passage of gas
- _____ is a burning or gnawing type discomfort
- _____ it travels to your right shoulder or between your shoulder blades

Have you recently had a change in bowel habits? Yes/No

Please check any of these that relate to your symptoms

- _____ crampy pain in abdomen
- _____ alternating diarrhea and constipation
- _____ diarrhea
- _____ constipation
- _____ pain during or after bowel movement
- _____ bright red rectal bleeding with every bowel movement
- _____ bright red rectal bleeding infrequently
- _____ blood streaked on outside of stool
- _____ blood mixed in the stool
- _____ blood dripping into toilet bowl
- _____ mucous in stools
- _____ pencil thin stools
- _____ ribbon like stools
- _____ black stools, tarry, liquid-like
- _____ require use of strong laxatives or enemas frequently
- _____ a sense of incomplete evacuation after a normal bowel movement
- _____ symptoms associated with your menstrual cycle

Procedures

Joint Replacement _____

Heart Stent _____ (year)

Heart Pacemaker _____ (year)

Heart Defibrillator _____ (year)

Blood Transfusion _____ (year)

EKG _____ (year)

Have you ever had any of the following procedures?

Colonoscopy Date(s) _____

EGD (scope of stomach) Date(s) _____

Barium Enema Date(s) _____

Upper GI X-ray Date(s) _____

Abdominal Ultrasound Date(s) _____

Results (if known) _____

Results (if known) _____

CT scan of Abdomen Date(s) _____

MRI of Abdomen Date(s) _____

Have you ever had any of the following gastrointestinal problems? Circle all that apply.

Loss of Appetite	Diarrhea	Hepatitis (What type?) _____
Difficulty swallowing, liquids, solids, pills	Irritable Bowel Syndrome	Hemorrhoids
Pain with Swallowing	Colon Polyps	Lactose Intolerance
Gallbladder Disease	Colon Cancer	Diverticular Disease
Peptic Ulcer Disease	Crohn's Disease	Constipation
Ulcerative Colitis		

List all operations and/or hospitalizations:

Approx. Date	Diagnosis and/or Operation	Hospital	Doctor

FAMILY HISTORY

	Age	Please list any serious illnesses	Age at Death/Cause
Father			
Mother			
Sisters			
Brothers			
Children			

Has anyone in your family been diagnosed with the following?

Colon Cancer	Yes/No	Relationship/Age at diagnosis _____
Colon Polyps	Yes/No	Relationship/Age at diagnosis _____
Crohn's Disease	Yes/No	Relationship/Age at diagnosis _____
Ulcerative Colitis	Yes/No	Relationship/Age at diagnosis _____
Irritable Bowel	Yes/No	Relationship/Age at diagnosis _____

Menstrual History (if applicable)

Age at first period _____
 Age at menopause _____
 Number of pregnancies _____ Miscarriages _____
 Any history of heavy menstrual flow? Yes/No
 Any history of endometriosis? Yes/No
 Date of last menstrual period _____