History Form for New Patient

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Welcome to our practice, Pittsburgh Gastroenterology Associates! Please help us assess your healthcare needs by providing your medical history. Fill out the form and bring it when you come to our office or hospital. The more we know about you, the better we can help you. This will become part of your permanent, confidential health record.

1. Please enter the patient's information.

First (legal) Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____ Gender: ○ Female ○ Male

Mobile Phone: _____ Home Phone: _____ Email: _____

2. What medical problem or concern do you have?

_____ How long have you had this problem? _____

Please describe in detail the issue you're experiencing:

_____

_____

Please list any other questions or concerns you would like to discuss with the doctor:

_____

_____

3. Please check any symptoms: gastrointestinal

- ☐ Abdominal Pain or Cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Heartburn / Acid Reflux
- ☐ Sour or Bitter Taste
- ☐ Regurgitation
- ☐ Belching
- ☐ Lumpy Feeling in Throat
- ☐ Difficult Swallowing
- ☐ Painful Swallowing
- ☐ Food Getting Stuck
- ☐ Choke or Cough after Swallowing
- ☐ Bloating
- ☐ Excessive Gas
- ☐ Indigestion
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in Bowel Habits
- ☐ Change in Size of Stool
- ☐ Blood in Stool
- ☐ Dark or Tarry Stool
- ☐ Mucus in Stool
- ☐ Foul Odor to Stool
- ☐ Stool Incontinence or Leaking
- ☐ Hemorrhoids
- ☐ Anal Itching
- ☐ Anal Burning
- ☐ Decrease in Appetite
- ☐ Food Intolerance/Sensitivity
- ☐ Jaundice/Yellow Skin or Eyes
- ☐ Unexplained Weight Gain
- ☐ Unexplained Weight Loss

4. Contitutional (general):

- ☐ Fatigue, Weakness
- ☐ Fevers/Chills
- ☐ Night Sweats

5. Neurological:

- ☐ Headaches
- ☐ Dizzy/Lightheaded
- ☐ Numbness or Tingling
- ☐ Seizures
- ☐ Confusion

6. Eyes:

- ☐ Blurry/Double Vision
- ☐ Burning
- ☐ Redness

7. Ear/Nose/Throat:

- ☐ Hearing Loss/Ringing
- ☐ Sore Throat
- ☐ Sinus Problem/Hoarseness

8. Respiratory:

- ☐ Shortness of Breath
- ☐ Persistent Coughing
- ☐ Coughing up Sputum

9. Cardiovascular:

- ☐ Chest Pain or Pressure
- ☐ Rapid/Irregular Heart Beat
- ☐ Swelling in Legs or Feet

10. Genitourinary:

- ☐ Frequent or Burning Urination
- ☐ Urine Incontinence or Leaking
- ☐ Heavy Menses

11. Allergy/Immunology:

- ☐ Frequent Infections
- ☐ Past Anaphylaxis

12. Hematology:

- ☐ Bleed/Bruise Easily
- ☐ Enlarged glands
- ☐ Past Blood Transfusion

13. Musculoskeletal:

- ☐ Joint Pain or Swlling
- ☐ Muscle Pain
- ☐ Back pain

14. Skin/Breast:

- ☐ Breast Lump
- ☐ Skin Rash
- ☐ Itching

15. Psychiatric:

- ☐ Anxiety or Depression
- ☐ Memory Loss
- ☐ Problem Sleeping

16. Other Symptoms Not Listed:

_____

_____

17. Please check if you have been diagnosed or treated for the following GI disorders:

- ☐ Barrett's Esophagus
- ☐ GERD/Reflux
- ☐ Esophagitis
- ☐ Hiatal Hernia
- ☐ Gastritis
- ☐ Stomach or Duodenal Ulcer
- ☐ Peptic Ulcer
- ☐ Celiac Disease
- ☐ Irritable Bowel Syndrome
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ C.diff Infection
- ☐ Colon Polyps
- ☐ Hemorrhoids
- ☐ Fistula / Fissure
- ☐ Liver Disease
- ☐ Liver Cirrhosis
- ☐ Hepatitis
- ☐ Gallbladder Disease
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Esopahgeal Cancer
- ☐ Stomach Cancer
- ☐ Liver Cancer
- ☐ Pancreatic Cancer

Please explain more or list other conditions not stated above:

18. Have you had the following tests? If yes, please list the last test: when, where, and ordered by whom? (e.g. Jan 2017, St Clair Hospital, by Dr. John Smith). We will try to obtain the records.

- Colonoscopy:
- Upper Endoscopy (EGD):
- Abdominal Ultrasound:
- Abdominal CT:
- Abdominal MRI:
- Blood Work:

19. Please check if you have been diagnosed or treated for the following disorders:

☐ Anemia	☐ Anxiety / Depression	☐ Bipolar Disorder
☐ Asthma / COPD	☐ Sleep Apnea	☐ High Blood Pressure
☐ Afib	☐ Heart Attack	☐ Vascular Disease
☐ Blood Clots	☐ Arthritis	☐ Chronic Pain
☐ Diabetes	☐ Thyroid Disorder	☐ Immune Disorder
☐ HIV/AIDS	☐ MRSA / VRE Infection	☐ Kidney Disease
☐ On Dialysis	☐ Kidney Stones	☐ Headache / Migraines
☐ Neurologic Disorder	☐ Seizures	☐ Stroke/TIA

Please explain more or list other conditions not stated above:

20. Please list all hospitalizations, procedures, and surgical operations, including date, admitting physician, location, and reason or diagnosis (e.g. Gastric bypass, Jan 2011, by Dr. John Smith, St. Clair Hospital, obesity)

21. Please list all medications you are currently taking, including over-the-counter drugs, vitamins, herbs, aspirin, arthritis medications, etc. Describe Medication Name, Dose, Frequency, Ordered by, and Reason for Use (e.g. Prilosec, 40 mg, once a day, Dr. John Smith, Heartburn)

22. Do you have any allergies? Please list allergies (including latex) and reaction (e.g. Sulfa, skin rash).

23. Does any of your parents or siblings have the following history?

☐ Colon Cancer ☐ Esophageal Cancer ☐ Stomach Cancer ☐ Liver Cancer ☐ Pancreatic Cancer

If yes, please explain. Are there any other GI conditions in your parents or siblings?

_____

24. Marital status

○ Single ○ Married ○ Widowed ○ Divorced

25. Do you smoke?

○ Yes ○ No ○ Past

26. Do you drink alcohol?

○ Yes ○ No ○ Past

If yes, list products and approximate weekly consumption. _____ If past, date quit: _____

27. What is your occupation?

_____

28. Do you exercise regularly? Height and Weight.

○ Yes ○ No ○ // Height:_____ ○ Weight:_____

29. Diet

Do you consume coffee, tea, caffeinated products regularly, including chocolate, cola?
○ Yes ○ No

Do you often consume artificial sweeteners?
○ Yes ○ No

Do you have any food intolerance or allergies to foods?
○ Yes ○ No ○ If yes, please explain:

30. Do you use recreational drugs or medical marijuana?

☐ Yes. ☐ No. ☐ Past.

31. Health Maintenance

When was your last flu shot? _____ When was your last pneumonia shot? _____ When was your last mammogram? _____

32. Are there any questions, concerns, or anything else you want us to know? Please describe.

_____

_____

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