Bay Area Houston
Gastroenterology Associates

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HISTORY AND PHYSICAL FORM

NAME_____**AGE**_____**DATE OF BIRTH**_____

OCCUPATION_____**TODAY'S DATE**_____

PERSON WHO REFERRED YOU_____

MARTIAL STATUS_____ **SEX: MALE FEMALE**

FAMILY HISTORY

Have you or any member of your family had any of the following?

			WHAT RELATIVE	YOURSELF
Cancer or Leukemia	__NO	__YES		
Tuberculosis	__NO	__YES		
Diabetes	__NO	__YES		
Heart Attack	__NO	__YES		
Heart Trouble	__NO	__YES		
High Blood Pressure	__NO	__YES		
Stroke	__NO	__YES		
Epilepsy	__NO	__YES		
Bleeding Disorder	__NO	__YES		
Asthma	__NO	__YES		
Migraines	__NO	__YES		
Alcoholism	__NO	__YES		
Emphysema	__NO	__YES		
Stomach Ulcer	__NO	__YES		
Kidney Disease	__NO	__YES		
Sickle Cell Anemia	__NO	__YES		
Anemia	__NO	__YES		
Mental Illness	__NO	__YES		
Suicide	__NO	__YES		
Hepatitis	__NO	__YES		
Liver Disease	__NO	__YES		
Other Disease	__NO	__YES		

	Age if Living	Age died	Cause of death
FATHER			
MOTHER			
BROTHERS			
SISTERS			
CHILDREN			

PERSONAL HISTORY

How often do you smoke? _____ If so, how long? _____

Have you stopped? _____ When? _____

How much alcohol do you consume on average, per day or per week?_____

Are you on a special diet? _____ What diet? _____

Have you recently gained or lost weight? ___ NO ___ YES

Gained_____ Lost _____

SURGERIES			
Have you had any of the following?			
	NO	**YES**	**DATE**
Hemorrhoid Surgery			
Tonsils			
Appendix			
Gallbladder			
Small intestine			
Kidney			
Colon			
Thyroid			
Hernia (rupture)			
Stomach			
Breast			
Uterus			
Ovaries			
Prostate			

ALLERGIES		
Are you allergic to any of the following?		
	NO	**YES**
Penicillin		
Sulfa		

Other Antibiotics, if so please name

_____

_____

Allergies to any other Medicine?

_____

MEDICATIONS		
Please list all medications:		
Name	Strength	How often?

Other surgery or Hospitalizations _____

SYSTEM REVIEW
Do you have any of the following complaints?

GENERAL	NO	YES
Fever		
General Weakness		
Memory Loss		
Easy Bruising		
Diabetes		

HEAD		
Persistent Hoarseness		
Other		

SKIN		
Changing Mole		
Rash		

NECK		
Swelling		
Stiffness		
Lumps		

CHEST, HEART, LUNGS		
Shortness of breath		
Poor exercise tolerance		
High Blood Pressure		
Fluttering of Heart		
Chest Pain/Press. Attacks		
Frequent Cough		
Coughing up blood		
Wheezing		

GASTROINTESTINAL		
Poor Appetite		
Indigestion or Heartburn		
Difficulty Swallowing		
Nausea or Vomiting		
Abdominal pain/cramps		
Diarrhea		
Constipation		
Change in Bowel Habits		
Pass Blood from Rectum		
Black, Tar-Like bowel Movements		

KIDNEY	NO	YES
Kidney Stones		
Blood in Urine		
Pain/burning w/ Urination		
Difficult passing Urine		
Diff. Controlling urine		
Getting up to urinate		

WOMEN		
Possibly Pregnant		
Breast Lump		
Discharge from Nipple		
Vaginal Discharge		
Vag. Bleeding/Spotting (not with periods)		

MEN		
Prostate trouble		
Diff. having Erections		
Discharge from Penis		
Sore Penis		
Lump in Testicles		

BONES – JOINTS		
Painful Joints		
Swollen Joints		
Loss of muscle Strength		
Lump/Swelling in Muscle		
Back Pain		

PSYCHOLOGIC **Do you find your life:**		
Generally Unsatisfactory		
Boring		
Satisfactory		

Do you:		
Cry easily		
Feel anxious or Upset		
Difficulty with Sleep		