UG | UtahGastroenterology

Patient Medical History

Date:______________________

Patient Name:____________________________________ Birthdate:_____________________________
Pharmacy:____________________________Location:_____________________________________
Referring and/or Primary Care physician:____
Email Address:____
Briefly describe the reason(s) for your visit today:
1.____
2.____
3.____
4.____

List any tests that have been performed related to current problem(s): (ex: Labs, CT, US, MRI, Endoscopy)

Test Name	Date	Facility Performed
1.		
2.		
3.		
4.		

Current Medications and Dosage (include over-the-counter medications, vitamins, & supplements):

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

List any Allergies to medications (describe reaction):

1.	4.
2.	5.
3.	6.

Do you experience any of the following? (check all that apply)

	Nausea		Food sticking
	Vomiting		Difficulty swallowing
	Bloating		Heartburn (chest burning)
	Abdominal Pain		Chest pain
	Weight Loss		Indigestion (stomach area)
	Loss of Appetite		Intolerance to certain foods
	Yellow Skin/Eyes		Increased appetite
	Lack of control for stools		Rectal Itching
	Diarrhea		Rectal bleeding
	Constipation		Hemorrhoids

List any previous surgeries and medical conditions:	Date:
1.	
2.	
3.	
4.	
5.	

Continued on reverse side ⇨

Review of Systems (check all that apply)

	Fatigue		Feet swelling		Loss of interest or pleasure
	Fever		Poor circulation-hands, feet		Difficulty concentrating
	Sweat/Chills		Rapid, pounding heart		Oversleeping
	Rash		Cough		Difficulty sleeping
	Itching		Phlegm/blood production		Agitation/restlessness
	Easy bruising		Urine burning		Depression
	Change in vision		Frequent urination		Suicidal thoughts
	Pain in eyes		Blood in urine		Panic attacks
	Eye drainage		Muscle aching		Anxiety
	Change in voice		Joint pain/swelling		Muscle tension
	Sore throat		Bone, spine pain		Enlarged glands
	Ear aching, ringing		Backache		
	Sinus drainage		Leg cramps		
	Nose bleeds		Headache		
	Wheezing		Numbness		
	Chest pain		Imbalance		
	Shortness of breath		Lightheadedness		

Family History:

Relationship	Male/Female	Living/Deceased	Age	Disease and/or Cause of Death
Father	Male			
Mother	Female			
Brothers/Sisters				
Sons/Daughters				

Is there any history in the extended family of the following? (check all the apply)

	Cancer		Crohn's Disease/Ulcerative Colitis
	Ulcers		Irritable Bowel Syndrome
	Gallstones		Liver problems
	Coronary Artery Disease		Diabetes

Social History:

Primary language spoken:_____________________ Type of Employment:_______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Smoking History (amount and duration):____

Alcohol History (amount and duration):____

Caffeine Use (type, amount, and frequency): ____