PRINCETON GASTROENTEROLOGY ASSOCIATES
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(609) 924-1422

MEDICAL HISTORY

Please complete all pages prior to your office visit.

NAME: _____ **DATE:** _____init.___

A. Medical History

1. Hospitalizations and Surgery - List the year and the reason for hospitalization or the type of surgery performed.

_____ _____
_____ _____
_____ _____
_____ _____

2. Have you ever had any of the following (please circle):

Colon Cancer/Polyps	Anemia	Asthma	Diabetes
Reflux	Heart Attack	Emphysema/COPD	High Cholesterol
Ulcers	Angina /Angioplasty	Sleep Apnea	Arthritis
Gallstones	Arrhythmia/Afib	High Blood Pressure	Kidney Disease
Liver Disease	Heart Failure	Stroke/TIA	Thyroid Disease
Cancer: _____		Seizures	Depression

OTHER: _____
_____

3. Medications - please list all medications you are currently taking, with tablet size and dosage. Include over-the-counter medicines as well as those taken only as needed.

_____
_____
_____
_____
_____

4. Allergies - include medicines and other substances to which you are allergic. Describe the type of reaction you have had. Are you allergic to Latex?

_____
_____

B. Family History

1. List your close relatives along with the following information:

	Living/age	Deceased and Age @ death	Cause of death or Significant medical conditions
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

2. Is there a family history of Colon Cancer or polyps? Yes / No

3. Do any illnesses (such as those listed in question A-2) run in your family?
Please specify relation (i.e., aunt, grandparent, etc.)
Maternal: _____
Paternal: _____

C. Social History

1. Your marital status: _____ Your occupation: _____
Partner's/ Spouse's occupation: _____

2. Have you ever smoked? Yes / No Are you a current smoker? Yes / No
How many cigarettes per day: _____ For how long? _____
Alcohol? _____ Drinks per day or per week? _____
Caffeine? _____ How many cups of coffee or tea per day? _____

REVIEW OF SYSTEMS
Do you currently have any of the following (please circle):

1. Constitutional a. changes in sleep pattern b. chills c. fatigue d. fever e. headache f. night sweats g. pain h. systemic illness i. weight gain j. weight loss

2. Skin a. changes in nails b. changes in skin color c. dry skin d. hair loss e. hair thinning f. itching g. rash h. scars i. skin lesions j. swelling k. varicose veins

3. Head a. blurred vision b. fainting c. head trauma d. seizures e. headache - describe_____

4. Eyes a. diabetic eye disease b. visual blurring c. diminished vision in left/right/both eye(s) d. double vision e. eye pain f. glaucoma g. infection h. itching i. new glasses j. redness k. scotoma/flashing lights

5. Ears a. drainage b. earaches c. hearing loss d. ringing
Nose e. nosebleeds f. congestion g. postnasal drip h. sinus problems
Mouth i. bleeding gums j. trouble swallowing k. mouth sores l. sore throat m. hoarseness n. voice changes

6. Cardiac a. chest pain b. difficulty breathing c. swelling d. painful extremities e. swelling in extremities f. fatigue g. palpitations h. difficulty breathing at night i. fainting j. weight gain

7. Respiratory a. chest pain b. cough c. difficulty breathing d. coughing up blood e. dry cough f. difficulty breathing while lying down or sleeping g. cough with phlegm h. wheezing

8. Gastrointestinal a. abdominal pain b. change in bowel habits c. early fullness d. heartburn e. difficulty swallowing food f. loss of appetite g. nausea h. vomiting i. perianal itching j. rectal bleeding

9. Genital /Urinary a. blood in urine b. burning/painful urination c. frequency d. incontinence e. kidney stones f. sexual difficulties g. straining h. urgency i. UTI

***female* -** j. menopause k. post-menopausal bleeding l. excessive bleeding m. vaginal discharge n. pain with periods o. # of pregnancies _____

***male* -** p. testicle pain q. erectile dysfunction r. testicular masses s. penile lesion or discharge t. prostate enlargement u. weak stream

10. Musculoskeletal a. back pain b. difficulty walking c. joint pain d. joint stiffness e. joint swelling f. muscle cramps g. muscle pain h. scoliosis i. weakness of joints j. weakness of muscles

11. Endocrine a. cold intolerance b. excessive thirst c. excessive urination d. glucose intolerance e. glandular problems f. heat intolerance g. hormonal problems h. thyroid disease

12. Heme/Lymph a. anemia b. bleeding easily c. bruising easily d. delayed wound healing e. enlarged glands f. past transfusion g. phlebitis

13. Allergy/Immunology a. autoimmune disease b. environmental allergies c. frequent illness d. immunodeficiency e. immunosuppression f. seasonal allergies

14. Neurologic a. balance difficulty b. concussion c. convulsions d. dizziness e. frequent headaches f. gait disturbance g. memory loss h. numbness i. paralysis j. rigidity k. stroke l. tingling sensation m. tremor n. vertigo/spinning

15. Psychiatric a. anxiety b. confusion c. depression d. memory loss e. nervousness f. sleep problems g. thoughts or plans of hurting yourself

If you have circled any of the above, please provide more details if necessary:

#	**details (frequency, duration, severity, etc...)**
____	_____
____	_____
____	_____
____	_____
____	_____

How Did You Hear About Our Practice? PCP Family Friend Website Yellow Pages Insurance Company

What is the reason for your visit today?

Screening Colonoscopy History of Polyps Reflux Barrett's Esophagus

Active Problem:_____