SWEDISH COVENANT MEDICAL GROUP
Personal Health History Form
Gastroenterology

Patient Label

Referring Physician: _____

Family Physician: _____ Date: _____

Past Medical History: Have you ever been diagnosed with any of the following? (If yes, when did it start?)

__ Reflux
__ Barrett's
__ Esophageal Stricture
__ Stomach or Duodenal Ulcer
__ Irritable Bowel (IBS)
__ Diverticulosis/Diverticulitis
__ Crohn's Disease
__ Ulcerative Colitis
__ Colon Polyps
__ Colon Cancer
__ Celiac Disease

__ Abdominal Adhesions
__ Cirrhosis
__ Hepatitis B
__ Hepatitis C
__ Fatty Liver
__ Anemia
__ Hemochromatosis
__ High Blood Pressure
__ Valvular Heart Disease
__ Coronary Artery Disease
__ Heart Attack

__ Irregular Heart Beat/ Arrhythmia
__ High Cholesterol or Tryglycerides
__ Fibromyalgia
__ Tuberculosis (TB)
__ Arthritis
__ Asthma
__ Chronic Lung Disease/Emphysema
__ Diabetes
__ Thyroid Disease
__ Kidney Disease
__ Stroke/ TIA

__ Seizures
__ Parkinson's
__ HIV/AIDS
__ Glaucoma
__ Anxiety/Depression
__ Sleep Apnea
__ Other Cancer _____
__ Radiation Treatment
__ Other _____
_____
_____

Past Surgical History: Have you ever had any of the following operations or procedures?

__ Appendectomy
__ Gallbladder
__ Cardiac Surgery
__ Hemorrhoids
__ Stomach Ulcer Surgery
__ Colon Resection
__ Small Bowel Resection
__ Hysterectomy

Weight Loss/ Gastric Bypass
__ Fundoplication/Reflux or Hiatal Hernia _____

__ EGD Date: _____ Findings: _____
__ Colonoscopy Date: _____ Findings: _____
__ ERCP Date: _____ Findings: _____
__ Other - please list:

_____
_____
_____

Social History

Family Life
__ Single
__ Married
__ Widowed
__ Separated
__ Divorced
__ Civil Union

Alcohol Consumption
__ I do not drink Alcohol
__ I drink less than 3 drinks or alcohol weekly
__ I drink 3 or more drinks of alcohol weekly
__ I drink 2 or more drinks daily
__ Quit
__ I have a history of alcohol abuse

Tobacco Use
__ Never
__ No, quit in _____
__ I smoke Tobacco products:
How many packs/day ____ for how many years _____
__ Illicit Drugs use: __ No __ Yes

Physical Activity
Do you exercise: __ No __ Yes
How often? _____

Family History: Does any of the family have/had the following?

__ Unknown or Adopted __ I have no Family History of Colon Cancer or Colon Polyps

__ Asthma	Who: _____	Age Diagnosed: _____	
__ Heart Disease	Who: _____	Age Diagnosed: _____	
__ Hypertension	Who: _____	Age Diagnosed: _____	
__ Stroke	Who: _____	Age Diagnosed: _____	
__ Stomach Ulcer	Who: _____	Age Diagnosed: _____	
__ Irritable (spastic) Bowel	Who: _____	Age Diagnosed: _____	
__ Ulcerative Colitis/Crohn's Disease	Who: _____	Age Diagnosed: _____	
__ Diabetes	Who: _____	Age Diagnosed: _____	
__ Hypo/Hyperthyroid	Who: _____	Age Diagnosed: _____	
__ Colon Cancer	Who: _____	Age Diagnosed: _____	
__ Colon Polyps	Who: _____	Age Diagnosed: _____	Type: _____
__ Esophageal Cancer	Who: _____	Age Diagnosed: _____	
__ Celiac Disease	Who: _____	Age Diagnosed: _____	
__ Stomach Cancer	Who: _____	Age Diagnosed: _____	
__ Liver Cancer	Who: _____	Age Diagnosed: _____	
__ Pancreatic Cancer	Who: _____	Age Diagnosed: _____	
__ Other Cancer (please list)	Who: _____	Age Diagnosed: _____	
_____	Who: _____	Age Diagnosed: _____	Type: _____
_____	Who: _____	Age Diagnosed: _____	Type: _____
_____	Who: _____	Age Diagnosed: _____	Type: _____

Review of System: Do you currently have any of the following symptoms?

Gastrointestinal
__ Heartburn
__ Trouble Swallowing
__ Nausea
__ Vomiting
__ Abdominal Pain
__ Bloating
__ Flatulence
__ Diarrhea
__ Constipation
__ Painful Bowel Movement
__ Blood in Stools
__ Poor Appetite
__ Jaundice
__ Black/Tarry bowel movement
__ Vomiting Blood

Constitutional
__ Fatigue
__ Fever
__ Chills
__ Headache
__ Night Sweats
__ Unexplained Weight Loss

Eyes
__ Blindness
__ Eye Pain
__ Change in Vision

Skin
__ Rash
__ Color Change
__ Itching

Ears, Nose, and Throat
__ Decreased Hearing
__ Mouth Ulcers
__ Sore Throat
__ Hoarseness

Cardiovascular
__ Chest Pain
__ Heart Murmur
__ Palpitations/Fluttering
__ Fast/Slow Heartbeat

Respiratory
__ Shortness of Breath
__ Asthma/Wheezing
__ Cough

Urinary
__ Painful Urination
__ Urinary Frequency
__ Blood in Urine

Neurological
__ Loss of Consciousness
__ Seizures/Convulsions

Psych
__ Depression
__ Nervousness/Anxiety

Hematologic
__ Swollen Glands
__ Easy Bleeding/Bruising

Musculoskeletal
__ Joint Pain or Stiffness
__ Muscular Pain or Stiffness
__ Back Pain

Endocrine
__ Cold Intolerance
__ Heat Intolerance

Other Symptoms:

_____

_____

Do you have any medical allergies?

__ **I have none**

Medication Allergies: _____

What Medicines are you currently taking? (Use the back of this page if necessary)

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Provider Signature: _____ **Date:** ____ / _____ /_____