Treasure Valley Gastroenterology Specialists
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Board Certified Gastroenterology
Fellow American College of Gastroenterology

Patient: ______________________ **DOB:** __________ **DOS:** __________

MEDICAL HISTORY

Have we seen you before: **YES / NO** **When:** ______________________

Have we seen a family member: **YES / NO** **Name:** ______________________

Please describe in your own words why you are being seen: ______________________

Last Flu Shot: Pneumonia Shot: Dexa Scan: Colonoscopy: Mammogram:

PLEASE BRING A COPY OF ALL YOUR CURRENT MEDICATIONS, INCLUDING ANY OVER THE COUNTER MEDICINES, VITAMINS, OR HERBAL SUPPLEMENTS. (NAME, DOSE, TIMES A DAY)

PAST MEDICAL HISTORY – PLEASE CHECK IF YOU HAVE HAD ANY OF THESE

- ☐ Rheumatic Fever
- ☐ Angina Pectoris
- ☐ Heart Valve Replaced
  Mechanical Y / N
- ☐ Defibrillator Implant
- ☐ Heart Rhythm Problem
- ☐ Aortic Stenosis
- ☐ Mitral Valve Prolapse
- ☐ Other Valve Problem___________
- ☐ Heart Attack
- ☐ Vascular Graft/When___________
- ☐ Cardiac Stent/When____________
- ☐ Other Heart Disease
- ☐ High Blood Pressure
- ☐ Anemia
- ☐ Prophyria
- ☐ Prolonged Bleeding
- ☐ Blood Disease
- ☐ B-12 Deficiency
- ☐ Iron Deficiency
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Ulcers
- ☐ Colitis
- ☐ Irritable Bowl Syndrome (IBS)
- ☐ Arthritis – Rheumatoid
- ☐ Arthritis - Osteo
- ☐ Seizures / Epilepsy
- ☐ Stroke / TIA
- ☐ B-12 Deficiency
- ☐ Esophageal Problems
- ☐ Crohn's Disease
- ☐ Emphysema
- ☐ Frequent Lung Infections
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Gluten Allergy/Coeliac Disease
- ☐ Glucose G6PD Deficiency
- ☐ Lactose Intolerance
- ☐ Diabetes
- ☐ Hyperglycemic
- ☐ Migraines
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Thyroid Disorder Low/Hypo -or Hi/Hyper
- ☐ Gout
- ☐ Cancer, Type: ___________________
- ☐ Liver Disease / Jaundice
- ☐ Hepatitis A / B / C
- ☐ Immune Deficiency
- ☐ Depression
- ☐ Sleep Apnea
- ☐ Anxiety
- ☐ Anorexia/Bulimia
- ☐ Osteoporosis
- ☐ Osteopenia

List any other significant illness (exclude typical childhood) ______________________

List all surgeries (type & year) ______________________

List all serious injuries/accidents (type & year) ______________________

List all hospitalizations not included above (reasons & year) ______________________

List all allergies to medications (name & reaction) ______________________

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Patient: ______________________ DOB: __________ DOS: __________

MEDICAL HISTORY (CONT)

List any other allergies (food, tape, iodine, etc.) ______________________

____

____

PERSONAL HABITS

Occupation: ______________________

Marital Status: Married / Divorced / Single / Widow / Live With Partner

Do you use tobacco:	YES / NO	**Type:**________	**Amnt Daily:**________	**# of Years:** ______
Did you use before:	YES / NO	**Type:**________	**Amnt Daily:**________	**Quit Year:** ______
Do you drink alcohol:	YES / NO	**Type:**________	**Amnt Daily:**________	**# of Years:** ______
Did you drink before:	YES / NO	**Type:**________	**Amnt Daily:**________	**Quit Year:** ______
Do you use illegal drugs:	YES / NO	**Type:**________	**Amnt Daily:**________	**# of Years:** ______
Did you use before:	YES / NO	**Type:**________	**Amnt Daily:**________	**Quit Year:** ______
Do you drink caffeine:	YES / NO	**Type:**________	**Amnt Daily:**________	**# of Years:** ______
Did you drink before:	YES / NO	**Type:**________	**Amnt Daily:**________	**Quit Year:** ______

Do you think you may be pregnant: YES / NO **Have you felt like a victim of abuse:** YES / NO

Have you ever worried that someone may hurt you: YES / NO **If Yes was/is it:** PRIOR / NOW

Been tested for hepatitis: YES / NO **Been vaccinated for hepatitis A or B:** YES / NO When ________

Been tested for HIV/AIDS: YES / NO **Have you had a blood transfusion:** YES / NO **When:** ______

List any other aspects of your life that may affect your health: ______________________

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FAMILY MEDICAL HISTORY – CHECK IF ANY BLOOD RELATIVE HAS HAD THE FOLLOWING AND LIST WHO

☐Colitis ________	☐Liver Disease________	☐Anemia________	☐Cancer________
☐Colon Polyps ________	☐Cirrhosis________	☐Bleeding Disorder________	☐ Colon________
☐Pancreatitis________	☐Gall Bladder Stones________	☐Kidney Disease________	☐ Breast________
☐Ulcers ________	☐Crohn's Disease ________	☐Depression________	☐ Uterine________
☐Diabetes ________	☐Wilsons Disease ________	☐Hypertension________	☐ Thyroid________
☐Thyroid Disease______	☐Hemochromatosis ________		☐ Pancreatic________

	If Living		If Deceased	
	Age	**Health**	**Age**	**Cause**
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Brother(s)				
Brother(s)				
Sister(s)				
Sister(s)				
Son(s)				
Son(s)				
Daughter(s)				
Daughter(s)				