CONNECTICUT GI

HEALTH HISTORY

Date:_____

Patient Name_____ D.O.B.:_____

Do you require an interpreter? ☐ Yes ☐ No If yes, what language?_____

Do you have any mobility limitations? *Please select all that apply* ☐ NONE ☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair

Do you have any visual limitations? ☐ NONE ☐ Glasses ☐ Contacts ☐ Glaucoma ☐ Blind

Do you have any auditory limitations? ☐ NONE ☐ Decreased Hearing ☐ Hearing Aids-Left and/or Right ☐ Deaf

Do you wear dentures? ☐ NONE ☐ Upper ☐ Lower ☐ Partial ☐ Braces

Are you pregnant? ☐ Yes ☐ No

Date of last menstrual period:_____

REFERRING PHYSICIAN

Name:_____ Primary care physician? ☐ Yes ☐ No

OTHER PROVIDERS

Primary Care Physician:_____

Do you have a cardiologist? ☐ Yes ☐ No If yes, who is your cardiologist?_____

If yes to cardiologist, when was your last visit?_____

CURRENTLY ACTIVE SYMPTOMS AND OTHER CONDITIONS

Current Height:_____ Current Weight:_____

Select any of these symptoms or conditions you CURRENTLY have.

General: ☐ fever ☐ fatigue ☐ weight loss ☐ lack of appetite ☐ night sweats ☐ hoarseness ☐ headache ☐ rash ☐ itching ☐ NONE

Head, Ears, Nose & Throat: ☐ hoarseness ☐ headache ☐ NONE

Cardiovascular: ☐ chest pains ☐ swelling hands/feet ☐ fainting/blacking out ☐ leg cramps ☐ NONE

Genitourinary: ☐ blood in urine ☐ painful urination ☐ urinary frequency ☐ pelvic pain ☐ change in urinary stream ☐ NONE

Neurological: ☐ fainting ☐ seizures ☐ dizziness ☐ loss of consciousness ☐ weakness in extremities ☐ difficult speech ☐ NONE

Endocrine: ☐ cold intolerance ☐ heat intolerance ☐ excessive thirst ☐ excessive urination ☐ NONE

Musculoskeletal: ☐ physical disability ☐ joint stiffness ☐ backache ☐ NONE

Skin: ☐ rash ☐ itching ☐ NONE

Respiratory: ☐ difficulty breathing ☐ wheezing ☐ chronic cough ☐ NONE

Psychiatric: ☐ depression ☐ anxiety ☐ suicidal thoughts ☐ NONE

Blood: ☐ easy bruising ☐ NONE

Gastrointestinal: ☐ nausea ☐ vomiting ☐ change in bowel habits ☐ constipation ☐ diarrhea ☐ bloating ☐ heartburn ☐ abdominal pain ☐ abdominal swelling (ascites) ☐ food intolerance ☐ get full quickly at meals ☐ pain with bowel movement ☐ vomiting blood ☐ painful swallowing ☐ difficulty swallowing ☐ incontinence of stool ☐ belching ☐ black stool ☐ laxative use ☐ gas/flatulence ☐ bloody stool ☐ jaundice ☐ NONE

Breast: ☐ breast mass ☐ breast pain ☐ NONE

MEDICATIONS

☐ I am not taking any medications, vitamins or supplements.

Please list all medications you are currently taking.

Name of Medication_____ Dosage_____ Frequency_____ Reason_____

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Name of Medication_____ Dosage_____ Frequency_____ Reason_____

Name of Medication_____ Dosage_____ Frequency_____ Reason_____

Name of Medication_____ Dosage_____ Frequency_____ Reason_____

Name of Medication_____ Dosage_____ Frequency_____ Reason_____

ALLERGIES

Drug: ☐ NONE ☐ General Anesthetic ☐ Local Anesthetic ☐ Carbamazepine ☐ Codeine ☐ Insulin preparations ☐ Iodine ☐ NSAIDs ☐ Penicillin ☐ Phenytoin ☐ Sulfa drugs ☐ Tetracycline

Food Allergies: ☐ NONE ☐ Peanuts ☐ Eggs ☐ Seafood ☐ Wheat ☐ Shellfish ☐ Corn ☐ Dairy ☐ Soy

Environmental Allergies: ☐ NONE ☐ Animals ☐ Dust mites ☐ Latex ☐ Stinging insects ☐ Mold ☐ Wool ☐ Plant pollens (Hay Fever)

Other Allergies: *If any, please list reaction.*

1._____ Reaction_____

2._____ Reaction_____

3._____ Reaction_____

4._____ Reaction_____

5._____ Reaction_____

6._____ Reaction_____

7._____ Reaction_____

Have you or any family member had any problems with Anesthesia? ☐ Yes ☐ No If yes, please explain:_____

Have you ever been told that you were difficult to intubate? ☐ Yes ☐ No

SURGERIES *Please select all surgeries you have had. If you have not had any surgeries, please select NONE.*

☐ NONE	☐ Carpal Tunnel	☐ Shoulder Surgery	☐ Back Surgery	☐ Knee Arthroscopy
☐ Hip Replacement	☐ Knee Replacement	☐ Amputation	☐ AV Graft/AV Fistula Creation	☐ Angioplasty (heart)
☐ Cardiac Cath	☐ Cardiac Pacemaker Placement	☐ Cardiac Defibrillator Placement	☐ Coronary Artery Bypass Graft	☐ Aortic Aneurysm
☐ Weight Loss	☐ Heart Valve Replacement	☐ Cardiac Stent Placement	☐ Carotid Endarterectomy	☐ Colon Resection
☐ Hiatus Hernia Surgery	☐ Kidney Transplant	☐ Prostate Surgery	☐ Lysis of Adhesions (scar tissue)	☐ Appendectomy
☐ Brain Surgery	☐ Stomach Surgery	☐ Gall Bladder	☐ Tonsillectomy	☐ Stomach Ulcer
☐ Surgery for Obstructive Sleep Apnea		☐ Liver Transplant	☐ Tunneled Dialysis Catheter	☐ Cataract
☐ Thyroidectomy	☐ Cesarean Section	☐ Lumpectomy: ☐ L ☐ R ☐ Both	☐ Mastectomy: ☐ L ☐ R ☐ Both	☐ Breast Surgery
☐ Hysterectomy (Uterus Removed)		☐ Other _____		

PATIENT MEDICAL HISTORY *Please select from the list below if you have had any of the conditions listed below or select NONE.*

Cardiovascular

☐ NONE	☐ Abnormal EKG (ie. Atrial Fibrillation)	☐ Cardiac Catheterization	☐ Congestive Heart Failure	☐ Chest Pain/Angina
☐ Hardening of Arteries	☐ Heart Attack/MI	☐ Heart Stent	☐ High Cholesterol	☐ Hypertension
☐ Implanted Defibrillator	☐ Leg Cramps	☐ Pacemaker	☐ Peripheral Vascular Disease	☐ Palpitations
☐ Rheumatic Fever	☐ Swelling of hands/feet	☐ Other_____		

Non-Gastrointestinal Conditions

☐ NONE	☐ Fibromyalgia	☐ Multiple Sclerosis (MS)	☐ Lupus	☐ Arthritis
☐ Rheumatoid Arthritis	☐ Osteoporosis	☐ HIV/AIDS	☐ Gout	
☐ Antibiotic Treatment within last 3 months		☐ Other_____		

Cancer

☐ NONE	☐ Esophagus	☐ Ovaries	☐ Skin	☐ Liver
☐ Mouth/Throat	☐ Stomach	☐ Lungs	☐ Colon or Rectum	☐ Prostate
☐ Uterus	☐ Blood (e.g. Leukemia)	☐ Pancreas	☐ Breast	☐ Thyroid
☐ Other:_____				

Respiratory

☐ NONE	☐ Recent Pneumonia (within 1 month)	☐ Asthma	☐ Oxygen at Home	☐ Tuberculosis
☐ CPAP	☐ Difficulty Breathing/Shortness of Breath	☐ Chronic Cough	☐ Wheezing	☐ Sleep Apnea
☐ Recent Bronchitis (within 1 month)		☐ COPD/Emphysemia	☐ Other:_____	

Gastrointestinal

☐ NONE	☐ Reflux/Heartburn	☐ Difficulty Swallowing	☐ Painful Swallowing	☐ Barrett's Esophagus
☐ Esophageal stricture or narrowing		☐ Celiac disease or Sprue	☐ Hiatal hernia	☐ Belching
☐ Peptic Ulcer Disease (stomach ulcer or duodenal ulcer)		☐ Gas/Flatulence	☐ Diarrhea	☐ Constipation
☐ Blood in stool	☐ Black stool	☐ Ulcerative Colitis	☐ Crohn's Disease	☐ Change in bowel habits
☐ Pain w/bowel movement	☐ Nausea	☐ Vomiting	☐ Vomiting blood	☐ Bloating
☐ Abdominal pain	☐ Abdominal Swelling	☐ Anal Fissure	☐ History of Helicobacter Pylori (H. Pylori)	
☐ Irritable Bowel Syndrome	☐ Colon Polyp(s)	☐ Diverticulosis/Diverticulitis	☐ Hemorrhoids	☐ Pancreatitis
☐ Intestinal Infection (ie- C. Difficile)		☐ Get full quickly at meals	☐ Food intolerance	☐ Incontinence of stool
☐ Laxative use	☐ Colonoscopy in past	☐ Upper Endoscopy in past	☐ Other:_____	

Hepatic

☐ NONE	☐ Yellow skin and/or jaundice	☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C
☐ Cirrhosis	☐ Ascites	☐ Elevated Enzymes	☐ Other:_____	

Endocrine

☐ NONE	☐ Thyroid Disease	☐ Diabetes	☐ Heat Intolerance	☐ Cold Intolerance
☐ Excessive urination	☐ Excessive thirst	☐ Other_____		

Renal/Genitourinary

☐ NONE	☐ Chronic Renal Failure	☐ Renal Insufficiency	☐ Dialysis	☐ Kidney Stone(s)
☐ Urinary Tract Infection (Recurrent)		☐ Blood in urine	☐ Change in urinary stream	☐ Painful urination
☐ Urinary frequency	☐ Pelvic pain	☐ Other_____		

Heme/Blood

☐ NONE	☐ Anemia	☐ Treatment with anti-coagulant or blood thinner		☐ Clotting abnormality
☐ Sickle Cell	☐ DVT/Blood clot(s)	☐ Blood transfusion(s)	☐ Easy bruising	☐ Other_____

Neurological

☐ NONE	☐ Seizures	☐ Stroke/TIA	☐ Syncope/Fainting	☐ Weakness
☐ Dizziness	☐ Paralysis	☐ Parkinsons	☐ Other_____	

Breast

☐ NONE	☐ Breast Pain	☐ Breast Mass	☐ Other_____

FAMILY HISTORY

☐ My family history is unknown.

	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	No History
Cancer (Other Types)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐

Age the relative developed Colorectal Cancer, if known: ☐ 20's ☐ 30's ☐ 40's ☐ 50's ☐ 60's ☐ 70's ☐ 80+ ☐ Not Known

Have any of your blood relatives had Colon Polyps? ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son ☐ Other ☐ NONE

Age the relative developed Colon Polyps, if known: ☐ 20's ☐ 30's ☐ 40's ☐ 50's ☐ 60's ☐ 70's ☐ 80+ ☐ Not Known

Select from the list below if a relative - Parent, Grandparent, Sibling, Children, Aunt or Uncle has had one of the following:

☐ NONE	☐ Mental Illness	☐ Celiac Disease	☐ Blood Clots	☐ Stroke
☐ Prostate Cancer	☐ Breast Cancer	☐ Pancreatitis	☐ Diabetes	☐ Stomach Cancer
☐ Alcohol Abuse	☐ Liver Failure	☐ Sickle Cell	☐ Bleeding Disorder	☐ Uterine Cancer
☐ Liver Cancer	☐ Gallstones	☐ Hemochromatosis	☐ Ovarian Cancer	☐ Heart Attack
☐ Hepatitis B	☐ Autoimmune Hepatitis	☐ Crohn's Disease	☐ Hypertension	☐ Hepatitis C
☐ Irritable Bowel Syndrome	☐ Ulcerative Colitis	☐ Ulcer Disease	☐ Cirrhosis	☐ Esphageal Cancer
☐ Tuberculosis	☐ Cancer - Other	☐ Other:_____		

PERSONAL AND SOCIAL HISTORY

Do you live alone? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

How many times per week do you exercise?_____

Type of exercise?_____

Do you consume alcohol? ☐ Yes ☐ No

What type of alcohol do you drink?_____

Average number of drinks per week (now or in the past)?_____

Have you felt a need to cut down on alcohol? ☐ Yes ☐ No

What is your smoking status? ☐ Never Smoked ☐ Former Smoker ☐ Current every day smoker

How many years total have you smoked?_____

How many packs?_____ per_____

Do you use smokeless Tobacco? ☐ Current ☐ Former ☐ Never

Daily use of smokeless tobacco?_____

How many years total have you used smokeless tobacco?_____

Have you ever been exposed to 2nd hand smoke? ☐ Yes ☐ No

IV drug use or other recreational drug use? ☐ Yes ☐ No

Drug of choice? ☐ Marijuana ☐ Cocaine ☐ Crack ☐ Heroin ☐ Illicit Rx ☐ Other_____

Have you engaged in high risk behavior for HIV or other STD's? ☐ Yes ☐ No

If you drink Caffeine, how many drinks per day? ☐ 0 /day ☐ <1 /day ☐ 1 /day ☐ 2 /day ☐ 3 /day ☐ 4 /day ☐ 4+ /day

Do any males in your family have a history of heart attacks or sudden death under the age of 55? ☐ Yes ☐ No

Do any females in your family have a history of heart attacks or sudden death under the age of 65? ☐ Yes ☐ No

Have you ever had a Blood Transfusion? ☐ Yes ☐ No

Have you had any recent Foreign Travel? ☐ Yes ☐ No

Do you have any Body Piercings? ☐ Yes ☐ No

Do you have any Tattoos? ☐ Yes ☐ No

How often do you wear a seat belt when in a car? ☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100%

How much sun exposure do you get? ☐ frequently ☐ occasionally ☐ rarely ☐ remote

Use this space below to give us additional information you would like us to know regarding your health history or medications: