Dayton Gastroenterology, Inc.

(937) 320-5050
(800) 341-5055
www.daytongastro.com

Medical History

Today's Date _____

Name *(First, Middle, Last)* _____ Date of Birth _____

Medical History

Medical History – Please check any of the medical conditions for which you have seen a doctor.

- ❑ None
- ❑ Anemia
- ❑ Anxiety Disorder

Arthritis
- ❑ Osteoarthritis
- ❑ Rheumatoid

- ❑ Asthma

Cancer
- ❑ Breast
- ❑ Colon
- ❑ Esophageal
- ❑ Kidney
- ❑ Liver
- ❑ Lung
- ❑ Ovarian
- ❑ Prostate
- ❑ Stomach
- ❑ Uterine

- ❑ Celiac Sprue
- ❑ Colon Polyps
- ❑ Congestive Heart Failure
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Crohn's Disease

Dementia/Alzheimer's
- ❑ Dementia
- ❑ Alzheimer's

- ❑ Depression
- ❑ Diabetes

Diverticular Disease
- ❑ Diverticulitis
- ❑ Diverticulosis

- ❑ Emphysema

Esophageal Disease
- ❑ Barret's Esophagus
- ❑ Varices

- ❑ Fibromyalgia
- ❑ Gallstones
- ❑ Glaucoma
- ❑ Headache, migraine

Heart Arrhythmias
- ❑ Atrial Fibrillation
- ❑ Tachycardia
- ❑ Bradycardia
- ❑ SVT

- ❑ Heart Attack
- ❑ Heart Valve Disease
- ❑ Hemorrhoids

Hepatitis/Liver Disease
- ❑ Cirrhosis
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Hepatitis Other _____
- ❑ Jaundice

- ❑ Hiatal Hernia
- ❑ High Blood Pressure
- ❑ High Cholesterol (lipids)
- ❑ HIV
- ❑ Irritable Bowel Syndrome
- ❑ Kidney/Renal Disease
- ❑ Kidney Stones
- ❑ Pancreatitis
- ❑ Parkinson's Disease
- ❑ Reflux (GERD)
- ❑ Seizure disorder
- ❑ Sjogren's Disease
- ❑ Sleep Apnea/CPAP
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Ulcerative Colitis
- ❑ Other *(please list):*

_____
_____
_____

Surgical History

Surgical History – Please check any of the surgeries that you have had.

- ❑ None
- ❑ Appendix Removal
- ❑ Back Surgery
- ❑ Bilateral Tubal Ligation
- ❑ Blood Transfusions
- ❑ Carpal Tunnel Release

Colon Surgery
- ❑ Colectomy
- ❑ Partial Colectomy
- ❑ Colostomy
- ❑ Ileostomy

- ❑ C-Section

Feeding tube
- ❑ G tube
- ❑ J tube

- ❑ Gallbladder Surgery

Gastric Bypass/ Weight Loss Surgery
- ❑ Duodenal Switch
- ❑ Gastric Sleeve
- ❑ Roux en Y

- ❑ Heart Stents _____ *(mm/yyyy)*
- ❑ Heart Surgery/Bypass
- ❑ Heart Valve Replacement, Aortic
- ❑ Heart Valve Replacement, Mitral
- ❑ Hernia Repair
- ❑ Hiatal Hernia Surgery
- ❑ Hysterectomy
- ❑ ICD (Internal Cardiac Defibrillator)

Joint Replacement/Joint Surgery
- ❑ Hip replacement
- ❑ Knee replacement
- ❑ Shoulder replacement
- ❑ Joint Surgery_____

- ❑ Laparoscopy (abdominal)
- ❑ Liver Biopsy
- ❑ Lung Surgery
- ❑ Mastectomy (Breast) Surgery
- ❑ Pacemaker
- ❑ Prostate
- ❑ Small bowel resection

Throat/Mouth Surgery
- ❑ Tonsillectomy
- ❑ Adenoidectomy
- ❑ Wisdom Teeth
- ❑ Other _____

- ❑ Thyroidectomy
- ❑ Transplant
- ❑ Other *(please list):*

_____
_____
_____

Social History

What is your occupation? _____

Are you:
❑ Single ❑ Married ❑ Widowed
❑ Partner ❑ Divorced/Separated

Do you use tobacco?
❑ No
❑ Quit *(year)* _____ age started ____ age stopped ____
❑ Yes type _____
# of years ____ packs per day ____

Do you consume alcoholic drinks? ❑ No ❑ Yes ❑ Quit *(year)* _____
Type _____
Frequency/Amount _____

Do you drink/consume caffeine? ❑ No ❑ Yes
Type _____
Amount per day _____

Do you currently use recreational drugs? ❑ No ❑ Yes
Type _____
Frequency _____

Don't forget to complete the other side of this form >>

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Medical History (continued)

Today's Date _____

Name *(First, Middle, Last)* _____ Date of Birth _____

Family History

		Father	Mother	Children	Brother	Sister	Other Relatives
Colon	Colon or Rectal Cancer	❑ at age _____	❑ at age _____	❑ at age _____	❑ at age _____	❑ at age _____	❑ _____
Colon	Colon Polyps	❑ at age _____	❑ at age _____	❑ at age _____	❑ at age _____	❑ at age _____	❑ _____
Other	Crohn's Disease	❑	❑	❑	❑	❑	❑ _____
Other	Esophageal Cancer	❑	❑	❑	❑	❑	❑ _____
Other	Kidney Cancer	❑	❑	❑	❑	❑	❑ _____
Other	Liver Cancer	❑	❑	❑	❑	❑	❑ _____
Other	Liver Disease	❑	❑	❑	❑	❑	❑ _____
Other	Ovarian Cancer	N/A	❑	❑	N/A	❑	❑ _____
Other	Pancreatitis	❑	❑	❑	❑	❑	❑ _____
Other	Stomach Cancer	❑	❑	❑	❑	❑	❑ _____
Other	Ulcerative Colitis	❑	❑	❑	❑	❑	❑ _____
Other	Uterine Cancer	N/A	❑	❑	N/A	❑	❑ _____
Other	Other Cancer *(please specify):*	❑ _____ at age _____	❑ _____ at age _____	❑ _____ at age _____	❑ _____ at age _____	❑ _____ at age _____	❑ _____

Don't forget to complete the other side of this form >>

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Review of Systems

Today's Date _____

Name *(First, Middle, Last)* _____ Date of Birth _____

Review of Systems

Have you had any of these symptoms recently? Circle Yes or No.

Constitutional

• Weight loss	Yes	No
• Fever	Yes	No
• Fatigue	Yes	No

Eyes/Ears/Nose/Mouth/Throat

• Eye symptoms	Yes	No
• Blurred vision	Yes	No
• Vision loss	Yes	No
• Hearing loss	Yes	No
• Ringing in ears	Yes	No
• Mouth sores	Yes	No
• Taste change	Yes	No
• Sore tongue	Yes	No
• Sore throat	Yes	No

Respiratory

• Chronic cough	Yes	No
• Spitting up blood	Yes	No
• Wheezing	Yes	No

Cardiovascular

• Chest pain	Yes	No
• Shortness of breath	Yes	No
• Swelling of ankles	Yes	No

Gastrointestinal

• Poor appetite	Yes	No
• Difficulty swallowing	Yes	No
• Heartburn	Yes	No
• Nausea	Yes	No
• Vomiting	Yes	No
• Bloating	Yes	No
• Belching	Yes	No
• Regurgitation	Yes	No
• Constipation	Yes	No
• Diarrhea	Yes	No
• Abdominal pain	Yes	No
• Rectal pain	Yes	No
• Rectal bleeding	Yes	No

Genitourinary

• Burning with urination	Yes	No
• Blood in urine	Yes	No
• Incontinence of urine	Yes	No
• Irregular periods	Yes	No
• Number of pregnancies _____		
• Number of miscarriages _____		

Metabolic/Endocrine

• Cold intolerance	Yes	No
• Heat intolerance	Yes	No
• Excessive thirst	Yes	No
• Excessive urination	Yes	No

Neurological

• Headache	Yes	No
• Seizures	Yes	No
• Numbness	Yes	No
• Weakness	Yes	No

Psychiatric

• Confusion	Yes	No
• Memory difficulty	Yes	No
• Insomnia	Yes	No
• Depression	Yes	No
• Nervousness	Yes	No

Integumentary

• Rash	Yes	No
• Itching	Yes	No

Musculoskeletal

• Joint pain	Yes	No
• Back pain	Yes	No
• Muscle pain	Yes	No

Hematologic/Lymphatic

• Easy bleeding	Yes	No
• Easy bruising	Yes	No
• Anemia	Yes	No
• Enlarged glands	Yes	No
• Have you ever been rejected for blood/plasma donation?	Yes	No

Comments

Comments on any of the above symptoms: _____

Staff Only

Date form received **Initials of reviewer**

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Medications and Allergies - Please Print

Patient Info

Today's Date_____

Name *(First, Middle, Last)*_____ Date of Birth_____

Allergies/Reactions

Please list any allergies or reactions to medications, foods, latex or dyes.
Please list what type of reaction you experienced (example: difficulty breathing, hives, etc.)

_____

_____

_____

Medications/Dosages

Please list all your medications and doses. Include vitamins, herbal supplements and over-the-counter medications (example: ibuprofen, Advil, Aleve, aspirin, Excedrin, Motrin, etc.).

Medication	Dosage	How Often Taken

Pharmacy

Please provide the following information for your preferred pharmacy.

Pharmacy Name _____ Address _____

Pharmacy Phone Number _____