Northwestern Medicine®

ASSOCIATES IN GASTROENTEROLOGY & LIVER DISEASE

HEALTH HISTORY FORM

Name_____ Date_____

Date of Birth_____ Age_____ Referred By_____

Height_____ Weight_____ Primary Care Doctor _____

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined ☐ Unknown Race:_____

PHARMACY (name, location, phone/fax number) _____

REASON FOR YOUR VISIT TO THE OFFICE

☐ Heartburn	☐ Nausea	☐ Diarrhea	☐ Hemoccult + stools
☐ Difficulty swallowing	☐ Vomiting	☐ Constipation	☐ Anemia
☐ Painful swallowing	☐ Upper abdominal pain	☐ Narrowed stools	☐ Decreased appetite
☐ Regurgitation	☐ Lower abdominal pain	☐ Rectal pain/itching	☐ Weight loss
☐ Excessive belching	☐ Bloating	☐ Rectal bleeding	☐ Jaundice
☐ Chest pain	☐ Gas/flatulence	☐ Black stools	☐ Screening colonoscopy
☐ Abnormal liver tests		☐ Abnormal ultrasound or CAT scan	
☐ Personal history of colon polyps/cancer		☐ Family history of colon polyps/cancer	

☐ Other_____

Have you had any of the following done to evaluate for the cause of your symptoms?

- ☐ Laboratory tests or blood work
- ☐ Radiology imaging (x-rays, ultrasounds, CAT scans, MRIs, barium studies)
- ☐ Endoscopies (upper GI scope/EGD, ERCP, colonoscopy)
- ☐ Emergency room visits

If possible, we would greatly appreciate it if you would please bring any relevant medical records with you or have them faxed to our office in advance of your visit – Fax (847) 295-1574.

What medications have you tried to treat your symptoms with (non-prescription and prescription)?

_____

_____

ALLERGIES

☐ NONE	☐ Demerol	☐ Iodine dye	☐ Morphine	☐ Propofol	☐ Surgical tape
☐ Codeine	☐ Fentanyl	☐ Latex	☐ Penicillin	☐ Sulfa	☐ Versed

☐ Other_____

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Any prior difficulties with sedation or anesthesia (nausea/vomiting, high tolerance, other)? ☐ Yes ☐ No

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MEDICATIONS

Please be certain to include birth control pills, hormones, and **ALL non-prescription medications**, such as anti-inflammatories (i.e. aspirin, advil, motrin, aleve, ibuprofen), acid blockers (i.e. zantac, pepcid, tagamet, prilosec OTC), topical hemorrhoidal creams (i.e. anusol, preparation H), vitamins, and herbal supplements.

Medication	Dosage	Frequency

PAST MEDICAL ILLNESSES

Gastrointestinal

☐ Heartburn/GERD ☐ Gallstones ☐ Diverticulitis ☐ Anal fistula
☐ Hiatal hernia ☐ Pancreatitis ☐ Ulcerative colitis ☐ Anal fissure
☐ Gastritis ☐ Irritable bowel (IBS) ☐ Crohn's disease ☐ Stool incontinence
☐ H. pylori ☐ Spastic colitis ☐ Colon polyps ☐ Abnormal liver tests
☐ Ulcer ☐ Lactose intolerance ☐ Colon cancer ☐ Fatty liver
☐ Celiac disease ☐ Diverticulosis ☐ Hemorrhoids ☐ Hepatitis ☐ Cirrhosis

Cardiovascular

☐ High blood pressure ☐ Heart attack ☐ PVCs ☐ Mitral valve prolapsed
☐ High cholesterol ☐ Atrial fibrillation ☐ Rhythm disorder ☐ Rheumatic fever
☐ Angina ☐ Tachycardia ☐ Heart murmur ☐ Congestive heart failure

Pulmonary

☐ Sleep apnea ☐ Emphysema (COPD) ☐ Pulmonary embolism ☐ Lung cancer
☐ Asthma ☐ Pneumonia ☐ Sarcoidosis ☐ Pleurisy

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Neuropsychiatric

- ☐ Stroke
- ☐ TIA (mini-stroke)
- ☐ Multiple sclerosis
- ☐ Seizures
- ☐ Migraines
- ☐ Chronic headaches
- ☐ Parkinson's disease
- ☐ Myasthenia gravis
- ☐ Dementia
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Eating disorder
- ☐ ADHD
- ☐ Hormonal mood disorder

Hematologic

- ☐ Anemia
- ☐ Blood transfusion
- ☐ Blood clot
- ☐ Hemochromatosis
- ☐ Hodgkin's disease
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Myelodysplastic syndrome

Endocrine

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Thyroid nodule
- ☐ Goiter
- ☐ Thyroid cancer
- ☐ Pituitary problem
- ☐ Adrenal problem

Genitourinary

- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Kidney tumors/cysts
- ☐ Bladder cancer
- ☐ Urinary tract infections
- ☐ Bladder incontinence
- ☐ Prostate hypertrophy
- ☐ Prostate cancer
- ☐ Ovarian cyst(s)
- ☐ Ovarian cancer
- ☐ Uterine fibroids
- ☐ Uterine cancer
- ☐ Abnormal Pap smears
- ☐ Cervical cancer
- ☐ Endometriosis

Breast

- ☐ Fibrocystic breast changes
- ☐ Breast cancer

Musculoskeletal

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Fibromyalgia
- ☐ Polymyalgia rheumatic
- ☐ Lupus
- ☐ Gout

Eyes, Ears, Nose, and Throat

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Retinal detachment
- ☐ Allergic rhinitis
- ☐ Sinusitis
- ☐ Oral thrush
- ☐ Sjogren's

Dermatologic

- ☐ Eczema
- ☐ Psoriasis
- ☐ Vitiligo
- ☐ Alopecia
- ☐ Raynaud's syndrome
- ☐ Basal cell skin cancer
- ☐ Squamous cell skin cancer
- ☐ Melanoma

Oncologic

☐ Any other malignant tumors not previously mentioned:_____

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Infectious Disease

☐ Any communicable disease, such as hepatitis, HIV, or sexually transmitted disease?_____

☐ Any other hospitalizations or medical conditions not previously mentioned _____

_____

PREVIOUS SURGERIES AND PROCEDURES

☐ Gallbladder	☐ C-section	☐ Vasectomy	☐ Foot surgery
☐ Appendix	☐ Tubal ligation	☐ Prostate surgery	☐ Stent/angioplasty
☐ Groin hernia repair	☐ Total hysterectomy	☐ Tonsillectomy	☐ Heart bypass surgery
☐ Bowel obstruction	☐ Partial hysterectomy	☐ Sinus surgery	☐ Heart valve surgery
☐ Adhesion surgery	☐ Ovarian surgery	☐ Cataract surgery	☐ Pacemaker
☐ Colon resection	☐ Uterine ablation	☐ Lasik eye surgery	☐ Defibrillator
☐ Hemorrhoid surgery	☐ Cone biopsy/LEEP	☐ Arthroscopy	☐ Carotid surgery
☐ Anti-reflux surgery	☐ Benign breast biopsy	☐ Knee replacement	☐ Vascular surgery
☐ Weight loss surgery	☐ Lumpectomy	☐ Hip replacement	☐ Vein stripping
☐ D & C	☐ Mastectomy	☐ Back surgery	

☐ Any other surgeries not previously mentioned_____

SOCIAL HISTORY

Marital status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Occupation_____

# of Children_____ Years of Education_____ Preferred Language_____

Do you use tobacco currently? ☐ Yes ☐ No

Did you ever use tobacco products? ☐ Yes ☐ No When did you quit? _____

Number of packs per day?_____

How many years?_____

Do you drink alcohol? ☐ Yes ☐ No How many glasses do you drink per day? _____

How many glasses do you drink per week? _____

Any problems with alcohol or drug use? _____

Do you drink caffeine? ☐ Yes ☐ No Number of cups per day of caffeinated coffee?____

Number of cups per day of caffeinated tea? _____

Number of cups per day of caffeinated soda? _____

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FAMILY HISTORY

	Father	Mother	Son	Daughter	Brother	Sister	Grand-mother	Grand-father	Aunt	Uncle	Cousin
Colorectal cancer											
Colorectal polyps											
Celiac disease											
Crohn's disease											
Ulcerative colitis											
H. pylori											
Hemo-chromatosis											
Hepatitis B											
Hepatitis C											
Stomach cancer											
Uterine cancer											

REVIEW OF SYSTEMS

General

☐ Fatigue ☐ Weakness ☐ Fever ☐ Night sweats
☐ Weight loss

Eyes

☐ Glasses ☐ Vision changes ☐ Eye redness ☐ Color blindness
☐ Contacts

Ears/Nose/Throat

☐ Hearing loss ☐ Runny nose ☐ Mouth sores ☐ Tooth/gum problems
☐ Ringing in ears ☐ Nosebleeds ☐ Tongue sores

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Cardiovascular

- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath with exertion or sleep
- ☐ Ankle swelling/edema
- ☐ Varicose veins
- ☐ Blue color changes in hands with cold

Respiratory

- ☐ Cough
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Wheezing

Endocrine

- ☐ Intolerance to cold
- ☐ Excessive sweating
- ☐ Abnormal skin pigment
- ☐ Dry skin
- ☐ Intolerance to heat
- ☐ Excessive hunger
- ☐ Abnormal body hair
- ☐ Dry hair

Lymph nodes (glands)

- ☐ Swollen jaw
- ☐ Swollen neck
- ☐ Swollen underarm
- ☐ Swollen groin

Bones/Joints/Muscles

- ☐ Pain
- ☐ Swelling
- ☐ Stiffness

Skin

- ☐ Itching
- ☐ Rash
- ☐ Bruising
- ☐ Scaling

Neurologic

- ☐ Headaches
- ☐ Fainting
- ☐ Localized numbness
- ☐ Speech difficulty
- ☐ Dizziness
- ☐ Tremor
- ☐ Walking difficulty
- ☐ Memory difficulty

Genitourinary

- ☐ Blood in urine
- ☐ Burning urination
- ☐ Dark urine
- ☐ Frequent urination
- ☐ Frequent urination at night
- ☐ Urinary incontinence

Males:

- ☐ Slow urinary stream
- ☐ Difficulty initiating urination
- ☐ Penile discharge
- ☐ Breast enlargement

Females:

- ☐ Abnormal periods
- ☐ Menopause
- ☐ Vaginal discharge
- ☐ Breast lump(s)
- ☐ Breast pain
- ☐ Nipple discharge

Patient's or Legal Guardian's Signature_____ Date _____

Physician's Initials_____ Date_____