PERSONAL HISTORY FORM

Anne Arundel Gastroenterology Associates, P.A.

Name____ Age_______ DOB___________ Today's Date: ______________________

Sex: _____ SSN: __________________ Weight: Now ______One Year Ago______ Maximum______ When_______

PAST MEDICAL HISTORY

Please √ any that you have ever had

GENERAL
- □ Hayfever
- □ Seasonal Allergies
- □ Broken Bones (Location)
- □ Transfusion (Dates)

VACCINES RECEIVED
- □ Hepatitis A/B
- □ Pneumonia
- □ HPV
- □ Other

CANCER
- □ Type/Treatment

HEART
- □ High Cholesterol
- □ Hypertension
- □ Heart Murmur/Rheumatic Fever
- □ MI/Heart Attack
- □ Heart Failure
- □ Atrial Fibrillation
- □ Pacemaker/Defibrillator
- □ Blood Clots/DVT's

LUNGS
- □ Asthma
- □ Emphysema/COPD/Bronchitis
- □ Pneumonia
- □ Sleep Apnea

ENDOCRINE
- □ Hypothyroid
- □ Hyperthyroid
- □ Diabetes

GI
- □ Ulcers
- □ GERD
- □ Strictures
- □ Celiac Disease
- □ Food Allergies/Intolerance
- □ Colon Polyps
- □ Crohn's/Ulcerative Colitis
- □ Irritable Bowel Syndrome
- □ Chronic Laxative Use
- □ Anal Fissures
- □ Hemorrhoids
- □ Last Upper Endoscopy
- □ Last Colonoscopy

GU
- □ Prostate Enlargement/Prostatitis
- □ Stones
- □ Uninary Tract Infection

GYN
Live Births # Abortions/Miscarriages #
- □ C-Sections

Last Menstrual Period

Contraception

LIVER DISEASE
- □ Jaundice
- □ Gallstones
- □ Cirrhosis
- □ Other

INFECTIOUS DISEASES
- □ Shingles/Chickenpox
- □ Gonorrhea/Syphilis
- □ HIV/AIDS
- □ Polio
- □ Meningitis
- □ Herpes □ Genital □ Anal □Oral
- □ Tuberculosis
- □ Hepatitis A B C (circle)
- □ Mononucleosis
- □ Last Use of Antibiotics

DERMATOLOGIC
- □ Skin Cancer (Type/Location)
- □ Hives/Edema
- □ Eczema
- □ Psoriasis

RHEUMATOLOGIC
- □ Osteoarthritis
- □ Osteoporosis
- □ Arthritis □ Rheumatoid □ Other
- □ Gout
- □ Lupus
- □ SICCA Syndrome

MENTAL ILLNESS
- □ Depression
- □ Anxiety
- □ Schizophrenia
- □ ADD/ADHD
- □ Anorexia/Bulimia
- □ Bipolar

NEUROLOGIC
- □ Migraines
- □ Multiple Sclerosis
- □ CVA/Strokes
- □ Seizures/Epilepsy

SURGICAL HISTORY ↓ Date ↓
- □ Gallbladder
- □ Appendix
- □ Hernia □ Inguinal
- □ Vasectomy
- □ Hysterectomy
- □ Oophorectomy
- □ Tubal Ligation

MEDICATION ALLERGIES (Describe Reaction)

MEDICATIONS
(PRESCRIPTION & OVER THE COUNTER)

Name	Dose	Frequency

FAMILY HISTORY

	State of Health	Cause of Death
Father		
Mother		
Siblings		

Colon Polyps? _______ Crohn's/UC?________

Colon Cancer? _______ Celiac Disease?_______

Has any blood relative ever had:
Please √ any that apply.

- □ Cancer type?
- □ Colitis type?
- □ Diabetes
- □ Heart Trouble
- □ High Blood Pressure
- □ Stroke
- □ Liver Disease
- □ Ulcer Disease
- □ Gallbladder Disease

SOCIAL HISTORY

Did you ever smoke? No Yes

How long?

Do you smoke now? No Yes

How many per day?

If you quit, when?

Do you consume alcoholic beverages?

How much per week?

Have you ever used recreational drugs other than marijuana? No Yes

Do you have any tattoos? No Yes

Have you ever been treated for addiction to alcohol or drugs? No Yes

Circle: Single - Married - Divorced- Separated - Widowed

Do you live with your spouse? No Yes

How many children do you have?

Number in Household/Children

Your Occupation

Rev. 8/12/15

REVIEW OF SYSTEMS

Please ✓ any that you have or have had in the past 6 months.

GENERAL
- □ Appetite □ Good □ Fair □ Poor
- □ Energy Level □ Good □ Fair □ Poor
- □ Undesired Weight Loss/Gain
- □ Change in Mood
- □ Insomnia

SKIN
- □ Rash
- □ New Lesions
- □ Dryness of Skin
- □ Easy Bruising
- □ Change in Hair/Skin
- □ Itching

HEAD & NECK
- □ Change in Vision
- □ Ear Problems
- □ Nose/Gum Bleeds
- □ Frequent Colds/Sinusitis
- □ Loss of Taste
- □ Hoarseness/Laryngitis
- □ Recurrent Sore Throat
- □ Mouth Sores
- □ Enlarged Glands

LUNGS
- □ Shortness of Breath
- □ Chronic Cough (Dry?/Productive?)
- □ Painful Breathing

HEART
- □ Angina
- □ Pain Radiating to Arms, Neck, Chest
- □ Palpitations/Fluttering

HEART (continued)
- □ Leg Cramps on Waking/at Night
- □ Swelling/Edema
- □ Vein Problems

GI
- □ Belching/Burping
- □ Heartburn/Indigestion
- □ Trouble Swallowing
- □ Food Intolerances
- □ Nausea/Vomiting
- □ Vomiting Blood
- □ Black-Colored Stool/Melena
- □ Blood in Stool
- □ Diarrhea/Constipation
- □ Change in Bowels (Frequency/Appearance)
- □ Abdominal Pain/Cramps
- □ Rectal Pain

GU
- □ Frequent Urination
- □ Painful Urination
- □ Urination at Night
- □ Blood in Urine

JOINTS/MUSCLES
- □ Backaches
- □ Joint Pain/Swelling
- □ Weakness
- □ Altered Sensation

HORMONAL
- □ Hot Flashes
- □ Flushing
- □ Heat/Cold Intolerance

Please list any other conditions for which you are treated and/or with which you are diagnosed; additional medications; any other comments:

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Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Patient Signature ____________________________ Date____________

Reviewed by ____________________________ Date____________