Specialists in Gastroenterology
Medical History Form

This form will assist your doctor. It is completely confidential and will be a part of your medical record.

Name: ______________________________ Birth Date: ____________ Date: ________________

Chief Complaint: (What brings you in to see the Doctor today?)

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____
____

For this problem:

Where is it? ______________________________

How would you describe it? ____________________
____

What makes it better or worse? ___________________
____
____
____

When does it occur? ____________________

How severe is it? ______________________

When did it start? ______________________

How long does it last?
____
____
____

What other symptoms do you have?
____
____

Did you do anything differently that might have caused you to have these symptoms? ______________________
____

Have you been treated for this condition by someone else? If so, when and what did you have done?
____
____

Have you had any tests or lab work performed to clarify these symptoms? If yes, what?
____
____

Have you had colonoscopy or endoscopy? If yes, list dates and results? ______________________________
____
____
____

Social History

What is your occupation? ______________________ Full-time or Part-time? ______________

Years employed at this job? ____________________

Martial Status: Single ______ Married _____ Separated _____ Divorced _____ Widowed ____

Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of tobacco: Never _____ Previously, but quit _______ Current packs per day _____

Are you on any special diet? ____