Westside Gastrointestinal Specialists, PLLC
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PATIENT MEDICAL HISTORY **TODAY'S DATE:** _____

NAME: _____ DATE OF BIRTH: _____

REASON FOR VISIT: _____

MEDICATIONS AND SUPPLEMENTS: **PHARMACY:**_____ **PHONE:**_____

1. _____ dose _____mg times taken/day_____
2. _____ dose _____mg times taken/day_____
3. _____ dose _____mg times taken/day_____
4. _____ dose _____mg times taken/day_____
5. _____ dose _____mg times taken/day_____
6. _____ dose _____mg times taken/day_____
7. _____ dose _____mg times taken/day_____
8. _____ dose _____mg times taken/day_____
9. _____ dose _____mg times taken/day_____
10. _____ dose _____mg times taken/day_____

DO YOU TAKE ASPIRIN OR NSAIDS? YES_____ NO_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES_____ NO_____ IF YES, PLEASE LIST BELOW

1._____ 2. _____ 3. _____ 4. _____

IMMUNIZATIONS: **FLU** ___YES ___NO DATE REC'D_____ **HAV** ___YES ___NO DATE REC'D_____

PNEUMOCOCCAL ___YES ___NO DATE REC'D_____ **HBV**___YES ___NO DATE REC'D_____

BONE DENSITY: ___YES ___NO DATE REC'D_____ **TOBACCO USE**: ___YES ___NO

PREVIOUS GI HISTORY

Have you ever had a colonoscopy? _____ When? _____ Where? _____
(Lower Scope)

Have you ever had an EGD? _____ When? _____ Where? _____
(Upper Scope)

PERSONAL HISTORY OF: CIRCLE YES OR NO.

Irritable Bowel Syndrome	Y	N
Diverticular Disease	Y	N
Anemia	Y	N
Colon Polyps	Y	N
GI Reflux	Y	N
Liver Disease	Y	N
Peptic Ulcer Disease	Y	N
Heartburn	Y	N
Esophageal Stricture	Y	N
Colon Cancer	Y	N

Other_____

FAMILY HISTORY OF: CIRCLE ALL THAT APPLY.

	(father)	(mother)	(sibling)	
Colon Polyps	F	M	S	None
Colon Cancer	F	M	S	None
Peptic Ulcer Dis.	F	M	S	None
Irritable Bowel	F	M	S	None
Gallbladder Dis.	F	M	S	None
Liver Disease	F	M	S	None
Breast CA	F	M	S	None
Uterine CA	N/A	M	S	None
Ovarian CA	N/A	M	S	None

IN THE PAST SIX MONTHS, HAVE YOU HAD PROBLEMS WITH THE FOLLOWING? MARK YES OR NO.

Weight Loss	Y___	N___	Black Stool	Y___	N___
Fever	Y___	N___	Nausea	Y___	N___
Vomiting	Y___	N___	Diarrhea	Y___	N___
Chest Pain	Y___	N___	Blood in stool	Y___	N___
Painful/Difficulty Swallowing	Y___	N___	Abdominal pain	Y___	N___
Change in bowel habits	Y___	N___			
Constipation	Y___	N___			