Revere Health
Gastroenterology

# Comprehensive History Form

Today's Date:_____

Name:_____ Date of Birth:_____/_____/_____

Describe your main problem:_____

Where is your problem located?_____

How long have you had your problem?_____

When does this problem occur?_____

What were you doing when it started?_____

What other things happen with this problem?_____

_____

List previous hospitalizations / surgeries / serious injuries: When/Age

_____

_____

_____

_____

List other doctors you see:

_____

_____

List **allergies** you have:

_____

_____

_____

_____

_____

_____

_____

List **medications, suplements and vitamins** you've been taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Have you and/or your family ever had the following?**

| | You | Mother | Father | Brother | Sister |
|---|---|---|---|---|---|
| Colon Polyps | ❑ | ❑ | ❑ | ❑ | ❑ |
| Colon Cancer | ❑ | ❑ | ❑ | ❑ | ❑ |
| Liver Disease | ❑ | ❑ | ❑ | ❑ | ❑ |
| Celiac Disease | ❑ | ❑ | ❑ | ❑ | ❑ |
| Inflam. Bowel Disease | ❑ | ❑ | ❑ | ❑ | ❑ |
| Diabetes | ❑ | ❑ | ❑ | ❑ | ❑ |
| Heart Trouble | ❑ | ❑ | ❑ | ❑ | ❑ |
| Hypertension | ❑ | ❑ | ❑ | ❑ | ❑ |
| Lung Problems | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer | ❑ | ❑ | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ | ❑ | ❑ |
| Arthritis/Gout | ❑ | ❑ | ❑ | ❑ | ❑ |
| Convulstions | ❑ | ❑ | ❑ | ❑ | ❑ |
| Bleeding Tendency | ❑ | ❑ | ❑ | ❑ | ❑ |
| Mental Illness | ❑ | ❑ | ❑ | ❑ | ❑ |
| Deceased | | ❑ | ❑ | ❑ | ❑ |

**Patient Social History:** Who lives with you? ❑ Spouse ❑ I live alone ❑ Other_____

What is your current occupation?_____ **or** ❑ Retired _____

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Other_____

Do you drink alcohol? ❑ Never ❑ Rarely ❑ Moderately ❑ Daily

Tobacco use: ❑ Never ❑ Former (when_____) ❑ Current (How much/often?_____)

Use of Drugs: ❑ Never ❑ Type / Frequency_____

Caffeinated beverages: ❑ Never ❑ Rarely ❑ Moderately What kind? ❑ Coffee ❑ Soft Drinks

Have you had any problems of falling in the past year? ❑ No ❑ Yes- Describe_____

**Please answer all questions. Have you had any of the following during the past three months?**

## Constitutional

| | | |
|---|---|---|
| Good general health lately | No | Yes |
| Recent weight change | No | Yes |
| Fever | No | Yes |
| Chills | No | Yes |
| Fatigue | No | Yes |

## Eyes

| | | |
|---|---|---|
| Eye disease or injury | No | Yes |
| Wear glasses/contact lenses | No | Yes |
| Blurred or double vision | No | Yes |
| Glaucoma | No | Yes |

## Ear, Nose and Throat

| | | |
|---|---|---|
| Hearing loss | No | Yes |
| Ringing in the ears | No | Yes |
| Earaches or drainage | No | Yes |
| Sinus problems | No | Yes |
| Nose bleeds | No | Yes |
| Mouth sores | No | Yes |
| Bleeding gums | No | Yes |
| Bad breath or bad taste in mouth | No | Yes |
| Sore throat or voice change | No | Yes |
| Swollen gland in neck | No | Yes |

## Cardiovascular

| | | |
|---|---|---|
| Heart trouble | No | Yes |
| Chest pains | No | Yes |
| Sudden heart beat changes | No | Yes |
| Swelling of feet, ankles or hands | No | Yes |

## Respiratory

| | | |
|---|---|---|
| Frequent coughing | No | Yes |
| Spitting up blood | No | Yes |
| Shortness of breath | No | Yes |
| Asthma or wheezing | No | Yes |

## Gastrointestinal

| | | |
|---|---|---|
| Loss of appetite | No | Yes |
| Change in bowel movements | No | Yes |
| Nausea or vomiting | No | Yes |
| Frequent diarrhea | No | Yes |
| Painful bowel movements or constipation | No | Yes |
| Blood in stool | No | Yes |
| Stomach pain | No | Yes |

## Genitourinary

| | | |
|---|---|---|
| Frequent urination | No | Yes |

## Musculoskeletal

| | | |
|---|---|---|
| Joint pain | No | Yes |
| Joint stiffness or swelling | No | Yes |
| Weakness of muscles or joints | No | Yes |
| Muscle pain or cramps | No | Yes |
| Back pain | No | Yes |
| Cold extremities | No | Yes |
| Difficulty in walking | No | Yes |

## Skin

| | | |
|---|---|---|
| Rash or itching | No | Yes |
| Change in skin color | No | Yes |
| Change in hair or nails | No | Yes |
| Varicose veins | No | Yes |
| Breast pain | No | Yes |
| Breast lump | No | Yes |
| Breast discharge | No | Yes |

## Neurological

| | | |
|---|---|---|
| Frequent or recurring headaches | No | Yes |
| Light headed or dizzy | No | Yes |
| Convulsions or seizures | No | Yes |
| Numbness or tingling sensations | No | Yes |
| Tremors | No | Yes |
| Paralysis | No | Yes |
| Stroke | No | Yes |
| Head injury | No | Yes |

## Psychiatric

| | | |
|---|---|---|
| Memory loss or confusion | No | Yes |
| Nervousness | No | Yes |
| Depression | No | Yes |
| Sleep problems | No | Yes |

## Endocrine

| | | |
|---|---|---|
| Grandular or hormone problems | No | Yes |
| Thyroid disease | No | Yes |
| Diabetes | No | Yes |
| Excessive thirst or urination | No | Yes |
| Heat or cold intolerance | No | Yes |
| Dry skin | No | Yes |
| Change in hat or glove size | No | Yes |

## Hematological/Lymphatic

| | | |
|---|---|---|
| Slow to heal after cuts | No | Yes |
| Easily bruise or bleed | No | Yes |
| Anemia | No | Yes |
| Phlebitis | No | Yes |
| Past transfusion | No | Yes |
| Enlarged glands | No | Yes |

## Allergic/Immunologic

History of skin reaction or other adverse reactions to:

| | | |
|---|---|---|
| Penicillin or other antibiotics | No | Yes |
| Morphine, Demerol or other narcotics | No | Yes |
| Novocaine or other anesthetics | No | Yes |
| Aspirin or other pain remedies | No | Yes |
| Tetanus antitoxin or other serums | No | Yes |
| Iodine, methiolate or other antiseptics | No | Yes |

Patient Signature: _____

Physician Signature: _____

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Assessment:

Plan: