



Thank you for choosing Elms Digestive for your care today. We are committed to providing the highest quality of medical care for each of our patients.

Please complete all sections of this medical history questionnaire. These questions are designed to provide our physicians with crucial information to optimize your visit today. If you are uncertain about any section of the form, mark the section with a (?) and your nurse will review it with you. Thank you again for choosing Elms Digestive.

Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:
<u>Doctor You are Seeing Today (Circle One):</u> Adelman Florez Goodear Snyder		<u>Primary Care Physician:</u>	
		Date of your last visit with your primary care doctor:	

Please *briefly explain why* you are being seen today at Elms Digestive:

Are you currently experiencing any of the follow symptoms:

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Bloody Stools or Black Stools	<input type="checkbox"/> Bloating	<input type="checkbox"/> Change in bowel habits
<input type="checkbox"/> Change in Voice	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Epigastric Pain	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Vomiting Blood
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Yellowing of the skin	

<p>Have you recently undergone an X-Ray, CT, MRI, or any other radiologic test? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>**If you answered Yes, Date of Test: _____ Location: _____</p>
<p>Have you recently had your blood drawn? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>**If you answered Yes, Date: _____ Location: _____</p>
<p>Have you recently been hospitalized because of the problems you are being seen for today? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>**If you answered Yes, Date: _____ Hospital: _____</p>

Colonoscopy and Upper Endoscopy History

Complete if you have had a Colonoscopy or Upper Endoscopy (EGD) in the past

Colonoscopy: Year	Location	Physician
Upper Endoscopy (EGD): Year	Location	Physician

Medications

List your Prescribed Drugs and Over-The-Counter Drugs (include -vitamins and supplements)

<u>Name</u> of medication and <u>Why</u> the medication was prescribed	Dose/Strength	Frequency (Daily, twice a day, at bedtime, etc.)

Are you **currently** taking any of the following **blood thinning** medications:

- Clopedogrel (Plavix)
 Warfarin (Coumadin)
 Heparin
 Xeralto
 Pradaxa
 Eliquis

Allergies

*If you answer Yes to any of the following, please specify what reaction you had to the allergen in the space provided (rash, hives, difficulties breathing, etc.)

- | | | |
|---|---|--------------------------------|
| <input type="checkbox"/> Shellfish: _____
<input type="checkbox"/> Nuts: _____
<input type="checkbox"/> Eggs: _____
<input type="checkbox"/> Soy: _____
<input type="checkbox"/> Wheat: _____ | <input type="checkbox"/> Latex: _____
<input type="checkbox"/> Iodine: _____
<input type="checkbox"/> Sulfa Drugs: _____
<input type="checkbox"/> Penicillin: _____
<input type="checkbox"/> Codeine: _____ | List Any Additional Allergies: |
|---|---|--------------------------------|
- I do not have allergies to any medications.

Surgeries and Hospitalizations

Year	Name of Hospital	Surgery or Reason for Hospitalization

Have you ever had complications with Anesthesia? Yes No

If you answered **Yes**, please briefly explain complication:

Family Health History

Indicate if any of your family members listed below have been diagnosed with the following:

	Mother	Father	Sibling	Child	Grandparent	Uncle/Aunt	Other:
Colon or Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Esophageal/Throat Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

I do not have a family history of GI related cancers.

Social History

Are you currently, or have you in the past used any of the following substances:

- Caffeine (# of drinks per day) _____
 Tobacco (# of packs per day) _____
 Previously or Currently
 Alcohol (# of drinks per day) _____
 Illegal Drug Use (name of drug) _____

Have you been diagnosed and/or treated in the past or are currently being treated for the following diseases or disorders:

Cardiovascular

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Abnormal Heart Rate/Rhythm | <input type="checkbox"/> Angina (Chest Pain) | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Edema (Swelling) | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> History of Blood Clots |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> History of Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Peripheral Artery Disease | <input type="checkbox"/> Other: | | |

Eyes, Ears, Nose and Throat

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Double or Blurred Vision | <input type="checkbox"/> Glasses/Contacts |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Chronic Nose Bleeds | <input type="checkbox"/> Chronic Sinus Infections | <input type="checkbox"/> Other: |

Endocrine

- | | | | | |
|--|--|--|---|---------------------------------------|
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Hormone Replacement Therapy | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Osteoporosis |
|--|--|--|---|---------------------------------------|

Genitourinary

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Renal Failure | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Other: |

Hematologic/Immunologic/Lymphatic

- | | | | | | |
|---|---|--|---|---------------------------------------|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> HIV /AIDS | <input type="checkbox"/> HIV Exposure | <input type="checkbox"/> Immune Deficiency |
| <input type="checkbox"/> Hodgkin's Lymphoma | <input type="checkbox"/> Non-Hodgkin's Lymphoma | <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other: |

Musculoskeletal

- | | | | | | |
|------------------------------------|------------------------------------|--|--|------------------------------------|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Weak Grip | <input type="checkbox"/> Other: |
|------------------------------------|------------------------------------|--|--|------------------------------------|--|

Neurologic

- | | | | | | |
|--|--------------------------------------|--|-----------------------------------|--|--|
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Dementia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> History of Aneurysm | <input type="checkbox"/> History of Stroke |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Other: | | | |

Psychiatric

- | | | | | | |
|--|--|--|---|-----------------------------------|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Depression | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Post-Traumatic Stress Syndrome |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Other: | | | |

Skin

- | | | | | | |
|-------------------------------|-------------------------------------|---------------------------------|------------------------------------|--------------------------------|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Warts | <input type="checkbox"/> Other: |
|-------------------------------|-------------------------------------|---------------------------------|------------------------------------|--------------------------------|--|

Respiratory

- | | | | | | |
|--|--|---|------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> History of Pulmonary Embolism | <input type="checkbox"/> Other: | | | | |

Digestive

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Anal Fissures | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Appendix Problems | <input type="checkbox"/> Barrett's Esophagus | <input type="checkbox"/> Bowel Obstruction |
| <input type="checkbox"/> Colitis (Inflammation of the Colon) | <input type="checkbox"/> Clostridium Difficile | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Colon Polyps |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Diverticulosis/Diverticulitis | <input type="checkbox"/> Dysphagia (Difficulty Swallowing) | <input type="checkbox"/> Esophagus/Throat Cancer | <input type="checkbox"/> Gallbladder Problems |
| <input type="checkbox"/> Gastritis (Inflammation of the Stomach) | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) | <input type="checkbox"/> Helicobacter Pylori (H Pylori) | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Hepatitis A, B, C (Circle One) | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Jaundice (Yellowing of the Skin) | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Fatty Liver | <input type="checkbox"/> Liver Cancer | <input type="checkbox"/> Pancreas Problems | <input type="checkbox"/> Pancreatic Cancer | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Other: | | | |