



Naugatuck
Valley
Gastroenterology
Consultants, LLC.

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► **MEDICAL HISTORY FORM**

Name Date of birth Age

Reason for today's visit

Who referred you to this office

Height Weight Today's date

► **YOUR MEDICAL HISTORY**

	Yes	No	When		Yes	No	When
Alcoholism	Hemorrhoids	.....	.....	.....
Anemia	Hepatitis	.....	.....	.....
Arthritis	High Blood Pressure	.....	.....	.....
Asthma	HIV	.....	.....	.....
Bleeding Tendency	Jaundice	.....	.....	.....
Bone Disease	Kidney Disease	.....	.....	.....
Cancer/Tumor	Liver Disease	.....	.....	.....
Colitis	Migraine	.....	.....	.....
Crohn's Disease	Pneumonia	.....	.....	.....
Diabetes	Psych Illness	.....	.....	.....
Diverticulosis	Rheumatic Fever	.....	.....	.....
Emphysema	Stomach Ulcers	.....	.....	.....
Epilepsy	Stroke	.....	.....	.....
Glaucoma	Thyroid Disease	.....	.....	.....
Gonorrhea/Syphilis	Tuberculosis	.....	.....	.....
Heart Attack	Other	.....	.....	.....
Heart disease

► **GASTROINTESTINAL**

	Yes	No		Yes	No
Abdominal Pain	Diarrhea	.....	.....
Abdominal Tension	Gas	.....	.....
Poor Appetite	Indigestion/Heartburn	.....	.....
Black Tarry Stool	Nausea	.....	.....
Bowel Habit Changes	Rectal Bleeding	.....	.....
Constipation	Vomiting	.....	.....

► **OPERATIONS/SURGERY**

	Yes	No	When	Where
Gall bladder
Stomach
Kidney
Colon
Hysterectomy/Ovary
Appendix
Other (please explain)



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► **MEDICAL HISTORY FORM/PAGE 2**

Have you ever had any of the following?

	Date?	What Facility?
Barium swallow
Upper GI series
Barium enema
Ultrasound
CT/MRI abdomen/pelvis

Have you had any recent bloodwork? (Yes/No)

What kind?	Date?	What Facility?
.....
.....

Have you had any stool cultures? (Yes/No)

What kind?	Date?	What Facility?
.....
.....

Have you had any of the following?

	Date?	What Facility?
Endoscopy
Colonoscopy
ERCP
Liver Bx

	Yes	No	Number Per Day	How Many Years
Do you use tobacco now?
Do you use alcohol now?
Do you drink coffee now?

Race or nationality of parents

Have you lived or traveled outside the U.S.?

Where? When?

Have you received any blood transfusions? (Yes/No) When?

Please list all ALLERGIES to medication or other substances

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Please list all of your current medication and dose

.....

.....

.....

.....



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► **MEDICAL HISTORY FORM/PAGE 3**

This section is for your family's medical history.

	Yes	No	Who? (mother, father, sister, brother, child)
Alcoholism
Anemia
Arthritis
Asthma
Bleeding Tendency
Bone/Joint Disease
Cancer/Tumor
Colitis
Congenital Heart
Crohn's Disease
Diabetes
Diverticulosis
Emphysema
Epilepsy
Glaucoma
Gonorrhea, Syphilis
Hay Fever
Heart Attack
Heart Disease
Hemorrhoids
Hypertension
Jaundice
Kidney Disease
Liver Disease
Nervous Illness
Migraine
Pneumonia
Psychiatric History
Rheumatic Fever
Stomach Ulcers
Stroke
Tuberculosis

Is there any colon/intestinal cancer? (Yes/No) or Polyps? (Yes/No) in your family?

If yes, in which family member?

Is there any other information you want the doctor to know or are there any questions you may want the doctor to answer?
.....
.....
.....
.....
.....

[The corporation reserves the right to designate the individual to perform the service on its behalf.]