Valley Medical Group
Valley Health System

Today's Date: _____

PATIENT VISIT/MEDICAL HISTORY
GASTROENTEROLOGY

ALLERGIES/ADVERSE REACTIONS

Medications	**Reaction**	**Food/Other** (please list)	**Reaction**
☐ Aspirin		☐ Latex	
☐ Tetracycline		☐ Cipro/Levaquin	
☐ Flomax		☐ Cephalosporins	
☐ Macrobid		☐ Other:	
☐ Penicillin		☐ Other:	
☐ Sulfa		☐ Other:	

CURRENT MEDICATIONS (Please list all Prescription Drugs, Over-the-Counter Medications, Herbs and Vitamins that you are currently taking including aspirin)

Name of Medication/Herb/Vitamin	**Dosage** (mg/ml)	**Frequency**

GI PROCEDURE HISTORY

Procedure	**Year**	**Doctor**	**Facility**	**Findings**
Previous Endoscopy: ☐ Yes ☐ No				
Previous Colonoscopy: ☐ Yes ☐ No				
Number of colonoscopies in the last ten years _____.				

SURGICAL HISTORY (Please check previous surgeries that you have had, including date)

Procedure	**Date of Surgery**	**Procedure**	**Date of Surgery**
☐ Abdominal Surgery		☐ HEENT Surgery	
☐ AICD		☐ Orthopedic Surgery	
☐ Cardiac Catheterization		☐ Pacemaker	
☐ Cardiac Surgery		☐ Tonsillectomy/Adenoidectomy	
☐ Cardioversion		☐ Vascular Surgery	
☐ Coronary Artery Stent		☐ Other	
☐ Gastrointestinal Surgery		☐ Other	
☐ Genitourinary Surgery		☐ Other	

Patient Name_____ Date of Birth:_____

PAST MEDICAL HISTORY (Please check those items that apply)

☐ Abdominal Hernia	☐ Chronic Renal Failure	☐ Jaundice
☐ Abdominal pain	☐ Cirrhosis of the liver	☐ Kidney Problems
☐ Abnormal vaginal bleeding	☐ Constipation	☐ Kidney Stone Disease
☐ Alcoholism	☐ COPD	☐ Liver Disease
☐ Anemia	☐ Crohn's Disease or Ulcerative Colitis	☐ Loss of appetite
☐ Anxiety/Depression	☐ Dementia	☐ Loss of weight
☐ Arthritis	☐ Depression or Psych. Illness	☐ Nausea
☐ Asthma/Emphysema	☐ Diabetes Mellitus	☐ Palpitations
☐ Atrial Fibrillation	☐ Diarrhea	☐ Pancreatitis
☐ Back Pain	☐ Diverticulosis/ Diverticulitis	☐ Peptic Ulcer
☐ Belching	☐ Elevated Cholesterol	☐ Prostate Problems
☐ Black, tarry stools	☐ Frequent Urination	☐ Rectal pain or bleeding
☐ Bladder or Kidney Problems	☐ Gallbladder Disease	☐ Shortness of Breath
☐ Bleeding Tendencies	☐ Gastrointestinal Disease	☐ Stroke
☐ Cancer, Cervical	☐ GERD/Reflux	☐ Substance Abuse
☐ Cancer, Colon	☐ Heart Conditions	☐ Thyroid
☐ Cancer, Esophagus	☐ Heartburn/regurgitation	☐ Thyroid Problems
☐ Cancer, Kidney	☐ Hemoptysis	☐ Trouble swallowing/pain on swallowing
☐ Cancer, Other	☐ Hepatic/Liver Disease	☐ Ulcer
☐ Cancer, Pancreas	☐ Hepatitis	☐ Upper GI Bleed
☐ Cancer, Prostate	☐ Hiatal Hernia	☐ Urinary difficulty
☐ Cancer, Stomach	☐ High Blood Pressure	☐ Vaginal discharge or infection
☐ Celiac Disease	☐ High Cholesterol	☐ Vomiting
☐ Change in bowel habits	☐ Hypothyroidism	☐ Warfarin Management
☐ Chest Pain	☐ Incontinence	☐ Other
☐ Cholelithiasis/ Gallstones	☐ Inflammatory Bowel Disorder	☐ Other
☐ Chronic Cough	☐ Irritable Bowel Syndrome	☐ Other

Have you had an anesthesia reaction? ☐ Yes ☐ No Explain _____

Cat Scan? ☐ Yes ☐ No Ultrasound/Sonogram? ☐ Yes ☐ No

Upper GI Series? ☐ Yes ☐ No Barium Enema? ☐ Yes ☐ No

FAMILY HISTORY (Please indicate the family member, onset age, age of death -if applicable)

Condition	Relation (Mother, Father, Sister, Brother, Son, Daughter, Maternal Grandmother/Grandfather/Aunt/Uncle, Paternal Grandmother/Grandfather/Aunt/Uncle)	Age when Diagnosed	Age of Death
☐ Cancer, Colon			
☐ Cancer, Esophagus			
☐ Celiac Disease/ Sprue			
☐ Colon Polyps			
☐ Crohn's Disease or Ulcerative Colitis			
☐ Diabetes			
☐ Elevated Cholesterol			
☐ Heart Disease			
☐ Liver Disease/ Hepatitis			
☐ Stroke			

*Valley Medical Group is the "trading as" name for Valley Physician Services, PC, Valley Medical Services, PC and Valley Physician Services, NY PC

Patient Name_____ Date of Birth:_____

FAMILY HISTORY *continued…*

Condition	Relation (Mother, Father, Sister, Brother, Son, Daughter, Maternal Grandmother/Grandfather/Aunt/Uncle, Paternal Grandmother/Grandfather/Aunt/Uncle)	Age when Diagnosed	Age of Death
☐ Thyroid Disease			
☐ Other			
☐ Other			

SOCIAL HISTORY

Current Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Advance Directive: ☐ Yes ☐ No

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy Alcohol – Years of Use: _____

Alcohol Intake: How many drinks/weeks: _____

Caffeine Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Changes in family/social situation_____

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Specific ☐ Carbohydrate ☐ Cardiac ☐ Diabetic

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Smoking Status: ☐ Never ☐ Former ☐ Current Every Day ☐ Current Some Day ☐ Current Status Unknown

Smoking – How much? ☐ None _____Pack(s) Per Day _____Pack(s) Per Week Has smoked since age _____

Chewing Tobacco - How much? ☐ None _____Per Day

Hepatitis C: ☐ Yes ☐ No

Illicit Drugs: _____ Years of Use: _____

Tattoos: ☐ Yes ☐ No Location_____ Piercings: ☐ Yes ☐ No Location_____

Seat belts used routinely: ☐ Yes ☐ No