HISTORY

(PATIENTS: PLEASE FILL OUT SECTIONS IN BLUE)

Name_____ **Referring Physician** _____

Date of Birth_____**Age** _____ **Date of Visit** _____

Chief Complaint (Main Reason for Visit)

___ Abdominal pain
___ Abnormal X-ray or imaging exam
___ Abnormal liver enzymes
___ Anemia
___ Blood in stool
___ Colon screening
___ Constipation
___ Diarrhea
___ Change in Bowel Habits
___ Heartburn/Indigestion
___ Hepatitis C ___ Hepatits B
___ Nausea or vomiting
___ Swallowing difficulty
___ Weight loss/poor appetite
___ Other not listed: _____
_____
_____

Medical Problems

___ Arthritis _____
___ Asthma _____
___ Atrial fibrilation/other rhythm disturbance _____
___ Anxiety/Depression_____
___ Chronic bronchitis/emphysema _____
___ Congestive Heart Failure _____
___ Coronary artery disease/angina _____
___ Diabetes melitus_____
___ High blood pressure _____
___ High cholesterol/triglycerides _____
___ Kidney failure _____
___ Osteoporosis/osteopenia _____
___ Sleep apnea _____
___ Thyroid problems _____
___ Other_____
_____

Surgeries:

	Details	**Date / Hospital**
___ Appendectomy	_____	_____
___ Breast	_____	_____
___ Gallbladder	_____	_____
___ Hernia Repair	_____	_____
___ Hysterectomy / ovaries	_____	_____
___ Other intestinal / abdominal	_____	_____
___ Tonsilectomy	_____	_____
___ Stomach / duodenal ulcer	_____	_____
___ Surgery not listed above	_____	_____

Medications: (Include over the counter and herbal products)

Name	**Dose/Frequency**	**Condition being treated/Duration**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medications: (Include latex/tape, iodine and serious adverse reactions other than allergy)

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

 Patient Name: _____ DOB: _____ Date of Visit _____

Social History

Tobacco __No __Yes __Quit/when_____ Packs per day_____ # Years _____
Alcohol __No __Yes __Quit/when_____ Drinks per wk_____ # Years _____
Recreational Drug Use __No __Yes __Quit/when_____ __Used Needles Drugs used _____
Diet __vegetarian __lactose-free __caffeine free __diabetic __regular __other_____
_____
Marital Status __Married __Single __Divorced __Widow/widower __Occupation _____

Family History: (Include **age** of diagnosis in affected family member)

	Father	Mother	Brother/Sister
Colon cancer	_____	_____	_____
Colon polyp	_____	_____	_____
Uterine/ovarian cancer	_____	_____	_____
Stomach/small bowel cancer	_____	_____	_____
Breast cancer	_____	_____	_____
Liver disease	_____	_____	_____
Gallbladder disease	_____	_____	_____
Colitis/Crohn's disease	_____	_____	_____
Other	_____	_____	_____

Review of Systems: (check if you have any of the following and describe further in space below)

Gastrointestinal

__Y __N Heartburn/regurgitation
__Y __N Difficulty swallowing
__Y __N Painful swallowing
__Y __N Filling up quickly at meals
__Y __N Nausea or vomiting
__Y __N Abdominal pain
__Y __N Irregular bowel habits
__Y __N Bloating/gas
__Y __N Incomplete evacuation of bowels
__Y __N Symptoms improve with evacuation
__Y __N Blood in stool or on toilet paper
__Y __N Mucous in stool
__Y __N Loss of control of bowels

Respiratory/Lung

__Y __N Sleep apnea/CPAP mask
__Y __N Respiratory complications with sedation
__Y __N Chronic bronchitis/emphysema
__Y __N Difficulty breathing
__Y __N Persistent cough
__Y __N Asthma

Endocrine

__Y __N Diabetes
__Y __N Thyroid disease
__Y __N Osteoporosis/osteopenia

Neurologic

__Y __N Headaches
__Y __N Strokes/CVA
__Y __N Seizures

__Y __N Intolerance to milk
__Y __N Intolerance to other foods
__Y __N Jaundice
__Y __N Gallstones
__Y __N Hepatitis A, B, C, other
__Y __N Cirrhosis
__Y __N Fluid in abdomen (ascites)
__Y __N Pancreatitis

Skin

__Y __N Rash
__Y __N Itching
__Y __N Unusual hair loss

Cardiovascular

__Y __N Chest pain, pressure, angina
__Y __N Coronary artery disease
__Y __N High blood pressure
__Y __N Swelling in feet or legs
__Y __N Abnormal heart rhythm
__Y __N Prostate cancer/enlarged

Gynecology

__Y __N Pregnant now?
__Y __N Endometriosis
__Y __N Heavy periods

Psychiatric

__Y __N Depression
__Y __N Anxiety
__Y __N Suicide Attempt

General

__Y __N Decreased appetite
__Y __N Unexpected weight loss
__Y __N Unexpected weight gain
__Y __N Fatigue
__Y __N Fever or Chills

Eyes

__Y __N Blind field of vision
__Y __N Cataracts

ENT

__Y __N Hearing loss/ringing
__Y __N Sore throat/hoarseness
__Y __N Sinusitis/Sinus drainage

Renal/Urinary/Kidney

__Y __N Renal failure/insufficiency
__Y __N Electrolyte disturbances
__Y __N Kidney stones
__Y __N Difficulty with urination
__Y __N Urinary tract infections

Musculoskeletal

__Y __N Joint pain/arthritis
__Y __N Back/neck pain
__Y __N Muscle aching/weakness

Blood/Lymph

__Y __N Anemia
__Y __N Bruise easily
__Y __N Past blood transfusion
__Y __N Swollen/tender lymph node

Comments: _____
_____
_____
_____
_____
_____

 Patient Name: _____ DOB: _____ Date of Visit _____

Provider Notes (For Use by Office Staff) T_____ P_____ R_____ Weight_____ BP_____

(Location, Radiation, Quality, Severity, Timing, Duration, Context, Modifying factors, Associated symptoms)

Physical Exam: _____

Labs and Imaging: _____

Assessment/Plan: _____

Physician Signature _____

Rya Kaplan, M.D. *Robbie H. Taha, D.O.*