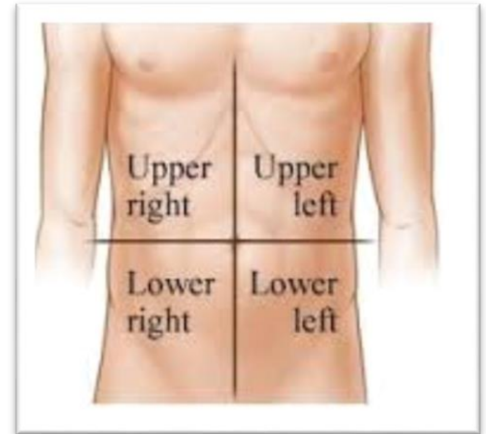
Medical History
Arizona Clinic Of Gastroenterolgy

Patient Name:______________________________DOB:____________Date:______________

GI Review of Symptoms:

Stomach Pain *(**if** experiencing stomach pain, place an **X** indicating where.)*



(Please circle the following that apply)

Heart Burn

Problems with eating

Nausea or Vomiting

Blood in stool or with bowel movement

Constipation or Diarrhea

General Review of Systems: ***(Please circle the following that apply)***

Fever

Nose Bleed

Chest Pain

Difficulty Breathing

Joint Pain or Muscle Pain

Anxiety or Depression

Past Surgical History: ***(Please circle the following that apply)***

Gallbladder Surgery

Endoscopy
- Upper Scope (EGD)
- Lower Scope (Colonoscopy)

Patient Name:_______________________________**DOB:**_____________**Date:**_______________

Family History:

Has anyone in your family ever had colon cancer? If **yes**, please indicate *who* and at *what age*.
Who? ____, **What Age?** ___________

Who? ____, **What Age?** ___________

Past Medical History: ***(Please circle the following that apply)***

Diabetes

High Blood Pressure

Heart Failure

Heart Attack

Irregular Heart Beat

Social History: ***(Please circle the following that apply)***

Smoker Never Smoked Previous Smoker

Do you drink alcohol? YES or NO

Do you currently use recreational drugs? YES or NO

Do you have a living will? YES or NO

List of Medications:

1.____________________________ **5.**____________________________

2.____________________________ **6.**____________________________

3.____________________________ **7.**____________________________

4.____________________________ **8.**____________________________

Are you allergic to any medications? If **yes**, please list the medications along with the reactions they cause.

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