La Jolla Gastroenterology Medical Group, Inc.

9850 Genesee Ave., Suites 820&930, La Jolla CA 92037, (858) 453-5200

THE PATIENT'S MEDICAL HISTORY

This information, as well as the results of your examinations, are confidential, and no report will be submitted to anyone except to a physician or institution at your request.

Patient Name: ____

Marital Status: ( ) single ( ) married ( ) separated ( ) divorced ( ) widowed

Date of Birth: ___________ Age ____ Place of Birth: _____________

Where have you lived most of your life? _________________________

When did you move to San Diego? _________________________

Referred by: Dr. ___________ Friend Yellow Pages Insurance

Primary Physician: ____

Other Physicians: ____

Reason for Evaluation: ____

MEDICATION ALLERGIES: ____________________________________

Medical Conditions (give approximate onset)	**Current Medications** (give dosages if known)	**Previous Surgeries** (list endoscopies & x-rays)
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
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________________	________________	________________
________________	________________	________________

Patient Name: _______________

FAMILY HEALTH State the age, health or cause of death in each:

Father: ________________________________

Mother: ________________________________

Brothers: ________________________________

Sisters: ________________________________

Did relatives have colon cancer or polyps? ( ) No ( ) Yes: Who? __________

SOCIAL HISTORY

What is or was your occupation? ____________________

What other occupations have you had? ____________________

What is or was your spouse's occupation? ____________________

Do you have children? If yes, give their age, occupation and health problems:

Sons: ________________________________

Daughters: ________________________________

PERSONAL HABITS

Exercise: What kind? How often? ____________________

Cigarettes: How many? Stopped? ____________________

Alcohol: What kind? How much? ____________________

Coffee or Tea: How much? ____________________

Do you avoid any foods or drinks? ____________________

GENERAL REVIEW

Have you recently lost or gained weight?	Yes	No
Have you recently had a fever?	Yes	No
Do you have skin rashes or hives?	Yes	No
Do you have frequent headaches?	Yes	No
Do you have glaucoma?	Yes	No
Does mild exercise cause shortness of breath?	Yes	No
Do you get chest pain with exercise?	Yes	No
Do you have an irregular heart beat?	Yes	No
Do you have difficulty urinating?	Yes	No
Do you have joint or back pain?	Yes	No

Patient Name: _______________

GASTROINTESTINAL REVIEW

Question		
Have you noticed a loss in appetite?	Yes	No
Have you ever been jaundiced (yellow)?	Yes	No
Do you have nausea or vomiting?	Yes	No
Do you have heartburn or acid reflux?	Yes	No
Do you have difficulty swallowing?	Yes	No
Do you have indigestion, gas, bloating?	Yes	No
Do you have diarrhea?	Yes	No
Do you have constipation?	Yes	No
Do dairy products cause gas, diarrhea or cramping?	Yes	No
Do you pass mucus in the stool?	Yes	No
Do you pass blood in the stool?	Yes	No
Did you have a change in bowel habits?	Yes	No

FUNCTIONAL BOWEL REVIEW

Question		
Is the abdominal pain aggravated by meals?	Yes	No
Is the discomfort relieved with bowel motions?	Yes	No
Do you have the sense of incomplete bowel motions?	Yes	No
Do you have more bowel motions with stomach pain?	Yes	No
Are the stools looser with the onset of pain?	Yes	No
Are the stools small, thin or broken up in pieces?	Yes	No
Are symptoms worse with stress?	Yes	No

PSYCHOSOCIAL REVIEW

Question		
Is your mood depressed?	Yes	No
Do you have decreased pleasure or interest?	Yes	No
Do you cry easily?	Yes	No
Do you experience fatigue or loss of energy?	Yes	No
Are you an anxious person or do you worry a lot	Yes	No
Do you have trouble sleeping or getting out of bed?	Yes	No
Do you experience breathlessness?	Yes	No
Do you have palpitations or chest pain/pressure?	Yes	No
Have you seen a psychiatrist or counselor?	Yes	No