FAYETTEVILLE GASTROENTEROLOGY ASSOCIATES, PA • 2041 VALLEYGATE DRIVE, SUITE 101, FAYETTEVILLE NC 28304

HEALTH HISTORY

Name *(Last, First, M.I.)*:	**DOB:**
Previous or referring doctor:	
What is the main reason for your visit to the doctor?	

MEDICATIONS

Please list all your medications, vitamins and herbs by name, dose, frequency, and start date.

Name the Drug		Dose	Frequency	Started
	Aspirin or aspirin-containing products			
	BC's, Goody Powders			
	Birth control pills			

Vitamins and Herbs

☐ Garlic ☐ Ginseng ☐ Gingko Biloba ☐Vitamin E ☐ Bilberry ☐ Turmeric ☐ Other ☐ Other

Allergies

1.	**3.**
2.	**4.**

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS?

GASTROINTESTINAL:

☐ Frequent Indigestion/heartburn	☐ Abdominal Pain	☐ Frequent Diarrhea
☐ Frequent Belching	☐ Decreased Appetite	☐ Blood in Stool
☐ Nausea	☐ Trouble Swallowing	☐ Recent Weight Loss-How many lbs?
☐ Vomiting	☐ Passing Excessive Gas	☐ Abnormal Stool, ribbon-like Stool
☐ Vomiting of Blood	☐ Change in Bowel Habits	☐ Fever
☐ Frequent Sore Throat	☐ Frequent Constipation	☐ Other:

PAST MEDICAL HISTORY:

☐ Esophageal Problems	☐ Heart Disease	☐ Thyroid
☐ Stomach Ulcer	☐ Enlarge Heart	☐ Stroke
☐ Gallstones	☐ Rheumatoid Fever	☐ Seizure
☐ Hepatitis/Jaundice	☐ Diabetes	☐ Headache
☐ Pancreatic Disorder	☐ Asthma	☐ Kidney Stones
☐ Colon Tumors (Polyps)	☐ Emphysema	☐ Cancer
☐ Colon/Rectal Cancer	☐ Vaginal Problems	☐ High Blood Pressure
☐ Arthritis	☐ High Cholesterol	☐ Other:

PLEASE COMPLETE BACK SIDE

Are you required to take **antibiotics** with any medial procedure?	☐ Yes ☐ No

OPERATIONS

Write in the names and years of any operations which you have had:

Year	Reason	Hospital

FAMILY HISTORY

GASTROINTESTINAL:

☐ Esophageal Cancer	☐ Pancreatic Cancer	☐ Heart Disease
☐ Stomach Ulcer	☐ Colitis	☐ High Blood Pressure
☐ Stomach Cancer	☐ Crohn's Disease	☐ Tuberculosis
☐ Gallstones	☐ Colon Polyps	☐ Cancer
☐ Hepatitis / Jaundice	☐ Colon Cancer	☐ Diabetes
☐ Pancreatitis	☐ Bleeding Disease	☐ Other

SOCIAL HISTORY

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse:		**Children:**	
Your Employment:		**Spouse Employment:**	

OTHER INFORMATION

☐ Tobacco Use?	How Long?	How Much?
☐ Alcohol Use?	How Long?	How Much?
☐ Recreational Drug Use?	How Long?	How Much?

☐ Coffee?	Cups per Day?	☐ Tea?	Cup per Day?

RECENT TESTS

☐ Upper GI x-ray	☐ Gallbladder x-ray	☐ Other
☐ Colon x-ray (barium enema)	☐ Sigmoidoscopy	☐ Other

Name of Person Completing the Form ______ Date ______ Name of Patient ______

Physician's Initials ______ Updated ______