Minnesota Gastroenterology, P.A.

New Patient HEALTH HISTORY

Patient to Complete and Bring in at Appointment

Dear Patient: Thank you for taking the time to complete this form prior to your appointment. PLEASE PRINT and fill out to the best of your ability. Spelling is NOT important. If you have trouble with any section, leave it blank, and the doctor can go over that area with you. Please arrive 20 minutes early for your appointment. If you need assistance with the entire form, inform the receptionist, and one of our staff persons will assist you.

NAME _____ **Date of Birth** _____**Age**_____**Today's Date** _____

Current Primary Care Physician _____ Physician who referred you to us _____

Symptoms or reason for this visit _____
When did your symptom or symptoms first begin? _____
How often do your symptoms occur? _____
Is there anything that gives relief (i.e., change in position, resting, etc.?) _____
Have you had any test (blood work, x-rays, etc.) pertaining to the reason for this visit? ___yes ___no
If so, when and where were they done? _____
Female patients: Date of your last pelvic examination _____

CIRCLE ANY GI SYMPTOMS WHICH YOU MAY HAVE:

Difficulty or painful swallowing (food or liquids become stuck)		Loss of appetite or weight
Heartburn/indigestion	Gaseousness/bloating	Distress from spicy or fatty foods
Vomiting/Nausea	Pain in abdomen	Jaundice (yellow eyes/skin)
Black or bloody stools	Rectal bleeding	Light colored stool
Constipation	Change in bowel habits	Diarrhea
Hemorrhoids	Eating disorder	Special Diet: (type) _____

In the past 12 months, have you experienced abdominal discomfort or pain for at least 12 or more weeks total (doesn't need to be continuous) yes/no (please circle). If you circled yes,
Was the dicomfort or pain relieved when you have a bowel movement? (yes/no)
When it began, did you have a change in the frequency of stool? (yes/no)
When it began, was there a change in the form (appearance) of the stool? (yes/no)

YOUR PERSONAL HEALTH HISTORY

When and where was your last colonoscopy? Date_____/_____/_____ Location:_____ N/A

Surgeries: Type of Operation, Where & What Year

_____
_____
_____
_____
_____
_____
_____

Medical History: Major or Chronic Illness & Date of Onset

_____
_____
_____
_____
_____
_____
_____

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YOUR FAMILY'S HEALTH HISTORY

(Enter which family member. If family member is deceased, at what age did they die?)

Colon or rectal cancer _____ Stomach Ulcer_____

Colon Polyps _____ Liver disease _____

Crohn's disease _____ Gallbladder disease _____

Ulcerative colitis _____ Other cancers _____

YOUR SOCIAL HISTORY

Your employment _____ Single/Married/Divorced (circle)

Who lives with you now?_____ Do you have children: _____Ages:_____

Smoking history (packs/day and # of years) _____ Milk Intake: _____

Exposure to toxic chemicals: _____ Exposure to Hepatitis C: _____

Vietnam Veteran: (yes/no) Tattoos or body piercings: (yes/no)

Have you ever used/experimented with I.V. drugs or "sniffing" drugs? (yes/no) When: _____

Current alcohol intake (amount, how often) _____

Past alcohol intake (amount, how often) _____

Have you traveled outside the U.S.: (when/where) _____

History of Blood Transfusion or blood products:_____ When: _____

Please circle if these symptoms are present:

General	Fever or chills, sweats, fatigue, weakness, lack of energy, bleeding tendency, weight gain or loss
Eyes, ears, nose, throat	Eye problems, ear problems, hoarseness, sore throat, sinus problems, mouth sores
Skin	Rash, flaking, itching
Heart	Chest pain, high BP, murmur, dizziness, fainting, ankle/leg swelling, poor circulation, palpitations
Lungs	Chronic cough, shortness of breath, spitting blood, asthma, bronchitis, emphysema
Endocrine	Diabetes, thyroid disease, thirst
Genitourinary	Frequent urination, painful urination, urgent urination, blood in urine, dark urine, venereal disease
Joints	Back pain, arthritis, joint or muscle pains
Neurological-psychiatric	Severe headaches, poor sleep, sadness/depression, crying spells, nervousness, seizures
Allergy/immune	Immune deficiency, hay fever

Explain above if needed:_____

_____

_____

_____

***continued on next page**

_____ _____

(Patient/Guardian Signature/Date) **(Reviewing Physician Signature/Date)**

Race/Ethnicity:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Latino or Hispanic
- ☐ White
- ☐ I do not wish to disclose

Allergies	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Latex? Yes/No If Yes, please describe: _____

Current Medications
(Including over-the-counter medicines such as aspirin, Tylenol, vitamins, herbs, supplements, etc.)

Name	Reason	Dose/How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____

Pharmacy Name/Location/Phone #: _____