Revere Health
Gastroenterology

Comprehensive History Form

Today's Date:________________________

Name:____ Date of Birth:______/______/__________

Describe your main problem:____

Where is your problem located?____

How long have you had your problem?____

When does this problem occur?____

What were you doing when it started?____

What other things happen with this problem?____

____

List previous hospitalizations / surgeries / serious injuries: When/Age

____

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____

List other doctors you see:

____

____

Have you and/or your family ever had the following?

	You	Mother	Father	Brother	Sister
Colon Polyps	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑
Liver Disease	❑	❑	❑	❑	❑
Celiac Disease	❑	❑	❑	❑	❑
Inflam. Bowel Disease	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
Heart Trouble	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑
Lung Problems	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑
Arthritis/Gout	❑	❑	❑	❑	❑
Convulstions	❑	❑	❑	❑	❑
Bleeding Tendency	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑
Deceased		❑	❑	❑	❑

List **allergies** you have:

____

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____

List **medications, suplements and vitamins** you've been taking**:**

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Patient Social History: Who lives with you? ❑ Spouse ❑ I live alone ❑ Other________________

What is your current occupation?______________________________ **or** ❑ Retired ____________________

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Other________________

Do you drink alcohol? ❑ Never ❑ Rarely ❑ Moderately ❑ Daily

Tobacco use: ❑ Never ❑ Former (when______________) ❑ Current (How much/often?________________)

Use of Drugs: ❑ Never ❑ Type / Frequency____

Caffeinated beverages: ❑ Never ❑ Rarely ❑ Moderately What kind? ❑ Coffee ❑ Soft Drinks

Have you had any problems of falling in the past year? ❑ No ❑ Yes- Describe______________________________

Please answer all questions. Have you had any of the following during the past <u>three</u> months?

Constitutional

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Chills	No	Yes
Fatigue	No	Yes

Eyes

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

Ear, Nose and Throat

Hearing loss	No	Yes
Ringing in the ears	No	Yes
Earaches or drainage	No	Yes
Sinus problems	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste in mouth	No	Yes
Sore throat or voice change	No	Yes
Swollen gland in neck	No	Yes

Cardiovascular

Heart trouble	No	Yes
Chest pains	No	Yes
Sudden heart beat changes	No	Yes
Swelling of feet, ankles or hands	No	Yes

Respiratory

Frequent coughing	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Blood in stool	No	Yes
Stomach pain	No	Yes

Genitourinary

Frequent urination	No	Yes

Musculoskeletal

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

Skin

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

Neurological

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Sleep problems	No	Yes

Endocrine

Grandular or hormone problems	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Dry skin	No	Yes
Change in hat or glove size	No	Yes

Hematological/Lymphatic

Slow to heal after cuts	No	Yes
Easily bruise or bleed	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

Allergic/Immunologic

History of skin reaction or other adverse reactions to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol or other narcotics	No	Yes
Novocaine or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, methiolate or other antiseptics	No	Yes

Patient Signature: ___________________________________

Physician Signature: ___________________________________

Assessment:

Plan: