

**GASTROENTEROLOGY ASSOCIATES**  
**DIRECT ACCESS – PATIENT HEALTH HISTORY**

**NAME:** \_\_\_\_\_ **D.O.B** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**REFERRING / FAMILY PHYSICIAN:** \_\_\_\_\_

**MEDICATIONS**

1. Please list all medications you are currently taking, along with their strength and frequency:

Medication	Strength	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Do you take any blood thinners (Aspirin, Plavix, Coumadin, Ticlid)?    Yes    No  
If so, please list: \_\_\_\_\_

3. Do you take over the counter non-steroidal anti-inflammatory medications (pain relievers),  
such as Ibuprofen, Advil, Aleve, Motrin, Naprosyn?    Yes    No  
If so, please list: \_\_\_\_\_

4. Do you take any herbal supplements or vitamins?    Yes    No  
If so, please list:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are you allergic to any medications?    Yes    No  
If so, please list:

Allergy	Reaction
_____	_____
_____	_____
_____	_____

6. Do you have any other allergies (food, tape, latex, dust, etc.)?    Yes    No  
If so, please list:

Allergy	Reaction
_____	_____
_____	_____
_____	_____

7. Please give the dates and results of the following studies that you have had:

	Year	Results
Upper Endoscopy (EGD)	_____	_____
Colonoscopy	_____	_____
Flexible Sigmoidoscopy	_____	_____
CAT Scan	_____	_____
Abdominal/Pelvic Ultrasound	_____	_____
Upper GI Series	_____	_____
Barium Enema	_____	_____
Hemoccult Cards	_____	_____

8. Please list any illnesses or medical problems that you have or have had in the past:

Problem	Year	Problem	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. Please list any surgeries or hospitalizations that you have had:

Reason	Year
_____	_____
_____	_____
_____	_____

10. Have you ever had a blood transfusion? Yes No

Reason	Year
_____	_____

### FAMILY HISTORY OF GASTROINTESTINAL ILLNESS

Please indicate which relatives have had the following illnesses (and at which age, if known):

	Mother	Father	Brother	Sister	Other
Colon Cancer	_____	_____	_____	_____	_____
Colon Polyps	_____	_____	_____	_____	_____
Crohn's Disease	_____	_____	_____	_____	_____
Ulcerative Colitis	_____	_____	_____	_____	_____
Diverticulitis	_____	_____	_____	_____	_____
Gallstones	_____	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____	_____
Ulcers	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Problems	_____	_____	_____	_____	_____
Ovarian Cancer	_____	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____	_____
Uterine Cancer	_____	_____	_____	_____	_____
Prostate Cancer	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Please elaborate: \_\_\_\_\_