



# Minnesota Gastroenterology, P.A.

## New Patient HEALTH HISTORY Patient to Complete and Bring in at Appointment

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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 discomfort 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

<b>Surgeries:</b> Type of Operation, Where & What Year	<b>Medical History:</b> 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:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_  
(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 #:** \_\_\_\_\_