Advanced Gastroenterology, Inc
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Health History Form

Name: **Date:** ______________________

Present illness (A brief description of your present complaint) Please print your answers.

Date issue started:

Review Of Current Symptoms Check All That Apply

Systemic ☐ None	Nose ☐ None	Cardio ☐ None	Gastrointestinal ☐ None	Urinary Tract ☐ None
☐ Weakness	☐ Nosebleeds	☐ Chest Pain/Discomfort	☐ Decreased Appetite	☐ Pain During Urination
☐ Tiredness	☐ Post Nasal Drip	☐ Chest tightness	☐ Nausea	☐ Burning w/ Urination
☐ Decreased Appetite		☐ Need to sit to breathe	☐ Vomiting	☐ Blood in Urine
☐ Weight Loss	**Throat** ☐ None	☐ Palpitations	☐ Difficulty swallowing	☐ Urinary frequency
☐ Chills	☐ Sore Throat	☐ Leg pain w/exertion	☐ Heartburn	☐ Urinary urgency
☐ Fever	☐ Hoarseness	☐ Soft tissue swelling	☐ Abdominal pain	☐ Inability to hold urine
☐ Night Sweats		☐ Short of breath when lying down	☐ Change in bowel habits	☐ Difficulty starting stream
☐ Difficulty Sleeping	**Neck** ☐ None		☐ Black stools	☐ Dark urine
	☐ Neck Pain	**Hematologic / Endocrine** ☐ None	☐ Red blood in stools	
Eyes ☐ None	☐ Bleeding Gums	☐ Easy Bruising	☐ BM frequency ______	**Neuro/Psych** ☐ None
☐ Double Vision	☐ Mouth Sores	☐ Excessive sweating	☐ Mucus in stools	☐ Headache
☐ Blurry Vision	☐ Gum Sores	☐ Sweating heavily at night	☐ Rectal pain	☐ Sleep Disturbances
☐ Yellowing of eyes		☐ Excessive Thirst	☐ Belching	☐ Numbness
	Respiratory ☐ None	☐ Temperature Intolerance	☐ Diarrhea	☐ Decrease in strength
Ears ☐ None	☐ Cough		☐ Constipation	☐ Depression
☐ Hearing Difficulty	☐ Cough up Blood	**Musculoskeletal** ☐ None	☐ Need for Antiacids	☐ Anxiety
☐ Ringing In Ears	☐ Chest pain w/breathing	☐ Arthralgias	☐ Jaundice	
	☐ Difficulty Breathing	☐ Swelling localized to one or more joints		
	☐ Wheezing	☐ Bone pain		
		☐ Other soft tissue complaints		

Please print your answers.

Allergies to Medications / Reactions (Any Food Allergies?)

☐ No ☐ Yes If yes, please specify:

____

Surgical History (Please Check All That Apply)			☐ NO PRIOR SURGERY	
☐ Eye Surgery	☐ Parathyroid Surg.	☐ Mastectomy	☐ D&C	☐ Orthopedic Surgery
☐ Adenoidectomy	☐ Heart Surgery	☐ Abdominal Surgery	☐ Tubal Ligation	☐ Spinal Surgery
☐ Tonsillectomy	☐ Heart Valve Repair	☐ Hernia Repair	☐ Cesarean Section	☐ Prostate Surgery
☐ Sinus Surgery	☐ Abdominal Aortic Aneurism	☐ Appendectomy	☐ Ovaries Removed	☐
☐ Thyroid Surg.	☐ Breast Lumpectomy	☐ Gall Bladder Removal	☐ Hysterectomy	
☐ Other:				

Personal Medical History				
☐ Headache/Migraine	☐ COPD	☐ Stomach Ulcer	☐ Kidney Stones	☐ Anxiety
☐ High Blood Pressure	☐ Pneumonia	☐ Gallstones	☐ Bladder Disorder	☐ Depression
☐ High Cholesterol	☐ Lung Problems	☐ Pancreatitis	☐ Prostate Disorder	☐ Bipolar Disorder
☐ Heart Disorder	☐ Sleep Apnea/Snoring	☐ Adrenal Disorder	☐ Venereal Disease	☐ HIV
☐ Diabetes Mellitus	☐ Heart Valve Disease	☐ Renal Disorders	☐ Osteoporosis	☐ Seizures
☐ Liver Disease	☐ Angina Pectoris	☐ Fibromyalgia	☐ Easy Bleeding	☐ Epilepsy
☐ Hepatitis	☐ Peripheral Vasc Dis.	☐ Arthritis	☐ Anemia	☐ Glaucoma
☐ Hepatic Disorders	☐ Chest Pain	☐ Osteoarthritis	☐ Recent weight loss	☐ Hearing Disorder
☐ Thyroid Disorders	☐ Congestive Heart Failure	☐ Rheumatoid Arthritis	☐ Tuberculosis	
☐ Pituitary/ Hypothalamic	☐ Heart Attack	☐ Colon Cancer	☐ Hemophilia	
☐ Chronic Sinusitis	☐ Stroke	☐ Breast Cancer	☐ Bleeding problems	
☐ Allerg.Rhinitis/Hayfever	☐ Heartburn	☐ Cancer - Other	☐ Brain Tumor	
☐ Asthma	☐ Reflux	☐ Prostate Cancer		
	☐ Peptic Ulcer			
☐ **Other Medical History**				

Previous Tests (Include Date) Please obtain reports for your upcoming visit or have them faxed to us (805)777-1730			
☐ Blood Counts - CBC	☐ Colonoscopy: _________	☐ Chest X-Ray: __________	☐ X-Ray _________________
☐ Blood Chemistry	☐ EKG: ___________	☐ CT Scan _________________	☐ Ultrasound _____________
☐ Fecal Analysis ________	☐ Cardio Stress Test: _______	☐ MRI Scan ________________	☐
☐ Cholesterol_____________	☐	☐	

Do you take any of the following medications? / Do any of these upset your stomach?

Medication	Dose/Frequency	Reason
☐ Aspirin		
☐ Ibuprofen/Motrin		
☐ Naprosyn/Naproxen		
☐ Plavix		
☐ Coumaden (warfarin)		

Do you take Antibiotics before surgery or dental work? ☐ Yes ☐ No

Please print your answers.

Other Medications & Dosages/Frequency (please include all non-prescription medications as well)		
☐	☐	☐
☐	☐	☐
☐	☐	☐
☐	☐	☐

Name of your Pharmacy & Location ____

Marital Status				
☐ Single	☐ Married, #Yrs: _____	☐ Separated	☐ Widowed	☐ Divorced

Social History (Check All That Apply)			
☐ Y ☐ N Regular Exercise	☐ Y ☐ N Caffeine Use	☐ Y ☐ N Alcohol Use	☐ Present use of Recreational Drug
☐ Y ☐ N Do You Smoke?	# Cups Of Coffee/Day: _____	# Drinks per day: _________ # Drinks per week: _________	☐ Past use of Recreational Drug
Cigarette packs per day: ______	# Cups of Tea/Day: ______	Artificial Sweetener use ☐ Y ☐ N	☐
☐ Y Stopped Smoking?	# of Colas/Soda: ________	Milk how many oz's per day:_____	

Family History									
Condition	**Mother**	**Dad**	**Sisters**	**Brother**	**Maternal Grand Mother**	**Maternal Grand Father**	**Paternal Grand Mother**	**Paternal Grand Father**	**Family History**
Alive or Deceased: Age?	☐ A_____ ☐ D_____	☐ A_____ ☐ D_____	☐ A_____ ☐ D_____	☐ A____ ☐ D____					
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gallbladder Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crohn's ileitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crohn's	☐	☐	☐	☐	☐	☐	☐	☐	☐
Granulomatous Colitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brain Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐		☐		☐		☐		☐
Uterine Cancer	☐		☐		☐		☐		☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐		☐		☐		☐		☐

Other History:

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☐ **Adopted: Family History Unavailable**

Gilbert Simoni, MD