MEDICAL HISTORY

Patient Name _____ DOB_____ Age_____
How did you hear about us? Referring Physician _____
Internist/Primary Physician _____
Pharmacy _____ Phone#_____
Have you ever been admitted to Cedars Sinai or treated in their ER? □ No □ Yes

CHIEF COMPLAINT- Check all that apply

□ Abdominal pain	□ Constipation	□ Nausea/Vomiting	□ Abnormal imaging/labs
□ Bloating/Gas	□ Rectal bleeding	□ Change in bowel habits	□ Gallbladder/Liver problems
□ Heartburn	□ Difficulty/Painful swallowing	□ Weight loss	□ Other
□ Diarrhea	□ Food stuck in esophagus	□ Colonoscopy screening	_____

Abdominal pain if yes, for how long? _____
Circle all that apply: Pain is Intermittnet/Constant/Burning/Sharp/Cramping/Dull Ache/Better with food/Worsened with food/Relieved by bowel movement/Relieved by passing gas/No relief with bowel movement or passing gas.
Severity: 1 (mild)-(10 severe)? _____
What improves the pain? _____
What worsens the pain? _____
Bloating if yes, for how long? _____
Circle all that apply: Worse with food/Excessive burping/Excessive gas/Recent antibiotics or travel.
Heartburn if yes, for how long? _____
Circle all that apply: Daily/Not often/Cough/Hoarseness/Awaken at night.
Relieved with medications? _____ If so, which meds? _____
Diarrhea if yes, for how long? _____
Circle all that apply: Blood present/Mucus present/Antibiotics in the past 3 months/Recent travel.
Number of bowel movements per day? _____
Constipation if yes, for how long? _____
Circle all that apply: Require laxatives or enemas/Sense of incomplete emptying/Straining.
Number of bowel movements per week? _____
Rectal Bleeding if yes, for how long? _____
Circle all that apply: Blood on toilet paper/Blood in toilet/Blood in stool/Rectal pain
Painful swallow if yes, for how long? _____
Circle all that apply: Liquids/Solids/Both. Do you take medication/s supplement at bedtime? _____
Food stuck in esophagus if yes, for how long? _____
Circle all that apply: Liquids/Solids/Both.
Vomiting/Nausea if yes, for how long? _____
Circle all that apply: Food/Bile/Both
Any weight change in the last 6 months? □ YES □ NO If yes, □ Loss or □ Gain. How many pounds? _____

PREVIOUS TESTING- Check all that apply

□ Colonoscopy	□ Wireless Capsule Endoscopy	□ Ultrasound	□ Blood test
□ Endoscopy	□ MRI	□ Lactulose breath test (SIBO)	□ Other
□ Sigmoidoscopy	□ CT Scan	□ Urea breath test (H.pylori)	_____

MEDICATIONS- List ALL prescriptions, supplements, and over the counter medications

Medication	Dose	Medication	Dose
1._____	_____	6._____	_____
2._____	_____	7._____	_____
3._____	_____	8._____	_____
4._____	_____	9._____	_____
5._____	_____	10._____	_____

ALLERGIES

□ No Known Drug Allergies □ Iodine □ Sulfa □ Aspirin □ Penicillin □ Other: _____

ISSUES WITH ANESTHESIA □ Yes □ No If yes please explain_____

MEDICAL HISTORY— Check all that apply

GASTROINTESTINAL
□ IBS(irritable bowel syndrome)
□ GERD/Heartburn
□ Gastritis
□ H.pylori infection
□ Peptic ulcer disease
□ Colon polyps
□ Hemorrhoids
□ Diverticulosis
□ Diverticulitis
□ Gallstones
□ IBD-Ulcerative Colitis
□ Pancreatitis
□ Chronic constipation
□ GI bleeding

HEART
□ High blood pressure
□ Heart attack
□ Angina
□ Congestive heart failure
□ Palpitations
□ Mitral valve prolapse
□ Hyperlipidemia
□ Heart valve disease
□ Endocarditis

LIVER
□ Cirrhosis
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Elevated liver test
□ Jaundice
□ Fatty liver

RENAL
□ Kidney stones
□ Kidney failure

NEUROLOGICAL
□ Stroke
□ Seizure
□ Migraines
□ Headaches

□ **RESPIRATORY**
□ COPD
□ Asthma
□ Tuberculosis
□ Sleep Apnea
□ Collapsed lung

CANCER
□ Colon cancer
□ Esophageal cancer
□ Stomach cancer
□ Breast cancer
□ Prostate cancer
□ Liver cancer
□ Leukemia

ENDOCRINOLOGY
□ Diabetes type I
□ Diabetes type II
□ Hyperthyroid
□ Hypothyroidism
□ Hyperthyroidism

INTEGUMENTARY
□ Skin cancer
□ Melanoma
□ Vitiligo
□ Eczema

MUSCULOSKETAL
□ Fibromyalgia
□ Rheumatoid arthritis
□ Raynaud's
□ Lupus
□ Sjogrens
□ Scleroderma
□ Gout

PSYCHOLOGICAL
□ Bipolar
□ Anxiety
□ Depression
□ OCD
□ Schizophrenia

BLOOD
□ Von Willebrand disease
□ Hemophilia
□ Bleeding or clotting

OTHER
_____
_____
_____
_____

SURGICAL HISTORY- Check all that apply

GASTROINTESTINAL
□ Appendix
□ Liver transplant
□ Hiatal hernia repair
□ Inguinal hernia repair
□ Gallbladder removal
□ Gastric bypass
□ Gastric banding
□ Sleeve gastrectomy
□ Gastric resection
□ Ventral hernia repair
□ Colonoscopy
□ Upper Endoscopy(EGD)
□ ERCP

CARDIAC
□ Heart stent placement
□ CABG (coronary artery)
□ Pacemaker
□ Defibrillator
□ Heart transplant
□ LVAD Device
□ Abdominal Aneurysm repair
□ Heart Valve replacement

GENITORURINARY
□ TURP
□ Bladder removal
□ Kidney transplant
□ Kidney removal
□ Prostatectomy

GYNECOLOGICAL
□ Hysterectomy
□ Ovary removal
□ C-section
□ Breast biopsy
□ Mastectomy

OTHER
□ Tonsillectomy
□ Thyroidectomy
_____
_____
_____
_____

FAMILY HISTORY- Check all diseases that have occurred in your family and **indicate family member**

	FAMILY MEMBER		FAMILY MEMBER
□ Crohn's Disease	_____	□ Liver Disease	_____
□ Ulcerative Colitis	_____	□ Hemochromatosis	_____
□ Peptic Ulcer Disease	_____	□ Gallstones	_____
□ Celiac Disease	_____	□ Pancreatitis	_____
□ Colon Polyps	_____	□ Breast Cancer	_____
□ Stomach Cancer	_____	□ Uterine Cancer	_____
□ Esophageal Cancer	_____	□ Cervical Cancer	_____
□ Pancreatic Cancer	_____	□ Heart Disease	_____
□ Colon/Rectal Cancer	_____	□ Other	_____

SOCIAL HISTORY

SMOKING: Do you **currently** smoke? □ Yes □ No If yes, how many packs per day? _____
Smoked in the past? □ Yes □ No If yes, when was your quit date? _____

ALCOHOL: Do you drink alcohol? □ Yes □ No If yes, how many times in a week? _____
How many drinks each time? _____

DRUGS: Do you use illicit drugs? □ Yes □ No If yes, how often? _____
Type: □ Cocaine □ Ecstasy □ Heroin □ Marijuana □ Pain medications □ Other IV Drugs _____

SEXUAL PREFERENCE: □ Heterosexual □ Homosexual □ Bisexual

GENERALIZED REVIEW OF SYMPTOMS– Check all that apply

CONSTITUTIONAL
□ Decreased appetite
□ Excessive fatigue
□ Night Sweats
□ Weight Loss

CARDIOVASCULAR
□ Irregular heartbeat
□ Leg swelling
□ Poor exercise tolerance
□ Chest Pain

ENDOCRINE
□ Excessive thirst
□ Cold intolerance
□ Menopause
□ Weight gain (10+ lbs)
□ Weight loss

PSYCHIATRIC
□ Suicidal Intention
□ Trouble Sleeping
□ Depression

NEUROLOGICAL
□ Dizziness
□ Headaches
□ Numbness/Tingling
□ Seizures

MUSCULOSKELETAL
□ Back pain
□ Recent injury
□ Swelling

HEMATOLOGICAL
□ Anemia
□ Bleeding and/or bruising
□ Blood transfusion

URINARY
□ Frequency of urination
□ Loss of bladder control
□ Burning with urination

ENT
□ Dentures/Partials
□ Ear pain/Ringing
□ Eye pain/Blurred vision
□ Hearing loss
□ Hoarseness
□ Inability to smell
□ Neck Lumps

RESPIRATORY
□ Chronic cough
□ Sleep Apnea
□ Shortness of breath
□Wheezing/Asthma

SKIN
□ Bruising
□ Itching
□ Jaundice
□ Rash
□ Skin cancer
□ Tattoo