cgim Center for Gastrointestinal Medicine
OF FAIRFIELD AND WESTCHESTER

PATIENT MEDICAL HISTORY FORM

Name:_____Date:_____

Height_____**Weight**_____ **Pharmacy**_____

Do you take any medication, herbal remedies, or over the counter medications? Y N
(If YES, please list)

Are you allergic to any medications? Y N (If YES, please list)

How often do you consume alcohol? monthly___ weekly__ daily___

How much caffeine do you consume daily? _____

Do you smoke? If yes how many cigarettes a day?_____ Did you smoke? How long ago?_____

Have you had Flexible sigmoidoscopy or colonoscopy Y N (If YES, When?)

List ALL medical condition for which you are under the care of a physician currently:

List ALL surgeries that you have had and the dates:

Family History: (Circle any that apply to blood relatives) Diabetes, High Blood Pressure, Heart Disease, Colon Cancer, Colon Polyp Disease, Ulcer Disease, Colitis, Crohn's Disease, Stroke, Gout, Epilepsy, Kidney Disease, Anemia, Asthma, Arthritis, Liver Disease, Other:

Review of Systems: (Circle symptoms that you are experiencing at this time)
No circle indicates a negative response.

Lack of energy	Vision changes	Chest pain	Trouble sleeping
Post nasal drip	Palpitations	Weight loss	Swollen legs
Sore throat	Weight gain	Voice Change	Diarrhea
Shortness of breath	Constipation	Excessive thrist	Painful menses
Coughing up blood	Chronic cough	Vomiting	Nausea
Rectal Bleeding	Abdominal pain	Joint swelling	Loss of appetite
Pregnancy	Heartburn	Joint redness	Numbness
New skin rash	Joint pain	Depression	Heartburn
Difficult Swallowing	Regurgitation	Back Pain	Tingling
Anxiety	Sour taste	Muscle Aches	Painful Urination