LAKESHORE GASTROENTEROLOGY & LIVER DISEASE INSTITUTE

PATIENT HEALTH HISTORY

FIRST AND LAST NAME _____ DATE OF BIRTH _____

PAST MEDICAL HISTORY

PLACE AN X IN THE BOX NEXT TO YOUR ASSOCIATED MEDICAL CONDITION

☐ Diabetes	☐ Asthma	☐ Stomach Cancer	☐ Abnormal Heart Rhythm
☐ Hiatia Hernia	☐ Depression	☐ Hepatitis	☐ High Cholesterol
☐ Fibromyalgia	☐ Liver Disease	☐ Rheumatic Fever	☐ High Blood Pressure
☐ Cystic Fibrosis	☐ Stomach Ulcer	☐ Diverticulitis	☐ Diverticulosis
☐ Heart Attack	☐ Anemia	☐ Crohn's Disease	☐ Ulcerative Colitis
☐ Colon Polyps	☐ Colon Cancer	☐ Breast Cancer	☐ Sleep Apnea
☐ Rectal Cancer	☐ Prostate Cancer	☐ Glaucoma	☐ GERD
☐ Stroke	☐ Blood Clots	☐ Kidney Disease	☐ Irritable Bowl Syndrome
☐ Arthritis	☐ Esophageal Cancer	☐ Cholelithiasis	☐ Barrett's Esophagus

Other: _____ Other: _____

FAMILY MEDICAL HISTORY

CIRCLE OR WRITE IN WHICH FAMILY MEMBER HAD ANY OF THE FOLLOWING CONDITIONS

Colon Polyps	maternal / paternal	Crohn's Disease	maternal / paternal
Ulcerative Colitis	maternal / paternal	Diabetes	maternal / paternal
Heart Disease	maternal / paternal	Gastric Cancer	maternal / paternal
Colon Cancer	maternal / paternal	Stomach Cancer	maternal / paternal
Other: _____	maternal / paternal		
Other: _____	maternal / paternal		

SURGERY HISTORY

PLEASE LIST ALL PREVIOUS SURGERIES.

Surgery	Year
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

CONTINUED ON NEXT PAGE

MEDICATION

PLEASE LIST ALL MEDICATION INCLUDING ALL OVER THE COUNTER MEDICATION, ANTACIDS, LAXATIVES, BIRTH CONTROL AND VITAMINS

Name of Medication	Dose	Times Per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Pharmacy Name:	City, State:

ALLERGIES

LIST NAME OF MEDICATIONS AND INCLUDE SEASONAL AND FOOD ALLERGIES

Allergen	Reaction
1.	
2.	
3.	
4.	
5.	

SMOKING HISTORY

MARK AN X IN THE BOX AND/OR FILL IN THE BLANKS

Do you smoke? ☐ Yes ☐ No **Quit: (Year)** _____

How many years have you smoked? _____ **How many packs per day have/did you smoke?** _____