DHP DIGESTIVE HEALTH PARTNERS

Patient Medical History

Name: _____ Date of Birth: _____ Phone:_____

Address: _____ Height:_____Weight:_____

GENDER ○ Male ○ Female ○ Additional gender category:_____ ○ Chooses not to disclose

RACE
○ White/Caucasian ○ Black/African American ○ Asian
○ American Indian/Alaska Native ○ Native Hawaiian or Other Pacific Islander ○ Patient declines to specify
○ Other ○ Unknown

ETHNICITY
○ Hispanic/Latino ○ Non-Hispanic or Latino ○ Patient declines to specify

PREFERRED LANGUAGE
○ English ○ Spanish ○ Other ○ Patient declines to specify

CONTACT PREFERENCE
○ Phone ○ Patient Portal ○Text ○ Patient declines to specify

FAMILY MEDICAL HISTORY ○ No family history ○ No knowledge of family history

	Mother	Father	Sister	Brother	Daughter	Son
Colon Cancer	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○
Celiac Disease	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○
Familial Multiple Polyposis Syndrome	○	○	○	○	○	○
PCC-hereditary nonpolyposis colon cancer (Lynch)	○	○	○	○	○	○
IBD (Crohn's or Ulcerative colitis)	○	○	○	○	○	○
Esophageal Cancer	○	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○

SOCIAL HISTORY

Occupation: _____ **Marital Status:** ○ Single ○ Married ○ Divorced ○ Widowed

Tobacco: ○ Current smoker, how much:_____ ○ Former smoker ○ Never smoker ○ Unknown if ever smoked

Drug Use: ○ Never ○ Former ○ Current – some use ○ Current – everyday use List drug:_____

Alcohol: ○ None ○ Rarely ○ Daily ○ More than 2 days/week ○ Less than 2 days/week ○ I quit using alcohol

Caffeine: ○ None ○ Carbonated drinks ○ Coffee ○ Energy drinks ○ Tea

DIAGNOSTIC STUDIES/TESTS - Please document date beside test if relevant (i.e. EGD 2017, Colonoscopy 2000, etc.).

○ No history of previous gastro tests ○ Other: _____
○ Colonoscopy ○ EGD ○ ERCP ○ Flexible Sigmoidoscopy
○ Bravo pH capsule ○ Pill cam ○ Esophageal Manometry ○ Liver Biopsy

ALLERGIES - ○ No known allergies ○ No known drug allergies
○ Latex ○ Adhesive Tape ○ Eggs ○ Soy ○ Codeine sulfate ○ Demerol
○ Fentanyl ○ Midazolam ○ Propofol ○ Penicillins ○ Salicylates ○ Sulfa (Sulfanamide, Abx)

○ Other allergies: _____

○ Please list reactions: _____

PREVIOUS PROCEDURES ○ No previous procedures ○ Other: _____

○ AAA surgery or repair	○ Appendectomy	○ Cardiac Defibrillator	○ Cardiac Stent placement
○ Carotid artery surgery	○ C-Section	○ Colon Resection	○ CABG
○ Cholecystectomy	○ Gastrectomy	○ Gastric Bypass Surgery	○ Hiatal Hernia Repair
○ Heart Valve Replacement	○ Hysterectomy	○ Ileostomy	○ Inguinal Hernia Repair
○ Joint Surgery/Replacement	○ Liver Transplant	○ Lung surgery	○ Lysis of adhesions
○ Mastectomy	○ Medication Pump	○ Nephrectomy	○ Pacemaker Insertion
○ PICC Line	○ Port-A-Cath	○ Prostate Surgery	○ Shunt/Graft/Fistula
○ Small Bowel Resection	○ Tonsillectomy	○ Tubal Ligation	

History of Procedure Complications ○ History of difficult airway/intubation ○ History of anesthesia complications ○ Problems with last procedure ○ History of Tracheostomy

If any anesthesia complications, explain: _____

Do you use continuous oxygen? ○ No ○ Yes If yes, how many liters?_____

MEDICAL CONDITIONS - Please document date beside event if relevant (i.e. Stroke 2017, Myocardial Infarction 2000, etc.)

○ No medical conditions

○ Achalasia	○ ALS	○ AAA - size?____	○ Adrenal Insufficiency	○ Anemia
○ Arthritis, Degenerative	○ Arthritis, Rheumatoid	○ Atrial Fibrillation	○ Asthma	○ Anxiety
○ Barrett's	○ Bleeding disorder	○ Blood transfusion	○ BPH	○ Breast Cancer
○ Brain Tumor	○ Bronchitis	○ Celiac Sprue	○ Cervical Cancer	○ Chronic fatigue
○ CHF	○ COPD, mild	○ CAD	○ Cirrhosis	○ Colon Cancer
○ Colon Polyps	○ Crohn's	○ Depression	○ Diabetes	○ Diverticulosis
○ Diverticulitis	○ Ehlers Danlos	○ Endometriosis	○ Emphysema	○ Esophageal Cancer
○ Esophagitis	○ Familial Adenomatous Polyps		○ Fatty Liver, non-etoh	
○ Fibromyalgia	○ Gallstones	○ Gastritis	○ GERD	○ Glaucoma
○ H-Pylori	○ Headaches	○ Heart Valve Disease	○ Hemorrhoids	○ Hepatitis A
○ Hepatitis B	○ Hepatitis C	○ Hiatal Hernia	○ High blood pressure	○ High Cholesterol
○ HIV/AIDS	○ Hyperthyroidism	○ Hypothyroidism	○ IBD	○ IBS
○ Iron Deficiency anemia	○ Irregular Heart rate	○ Ischemic colitis	○ Ischemic Vascular Ds.	○ Kidney Cancer
○ Kidney failure, chronic	○ Kidney stones	○ Leukemia, chronic	○ Liver Cancer	○ Liver Disease
○ Lung Cancer	○ Lymphoma	○ Lynch Syndrome	○ Melanoma	○ Metal in Body
○ Myocardial Infarction	○ Multiple Sclerosis	○ Obesity	○ Ovarian Cancer	○ Pancreatits, acute
○ Pancreatic Cancer	○ Prostate Cancer	○ Pulmonary HTN	○ Rectal Cancer	○ Renal Failure
○ RSD (Reflex sympathetic dystrophy)		○ Seizure disorder	○ Skin Cancer	○ Sleep apnea
○ Sleep Apnea w/CPAP	○ Strictures	○ Stomach Cancer	○ Stroke	○ Thrombocytopenia
○ TIA	○ Thyroid disorder	○ Tuberculosis, History	○ Ulcer Disease, Peptic	○ Ulcerative Colitis

○ Other: _____

PHARMACY *Do you consent to obtaining/importing a history of your medications purchased at pharmacies? ○ Yes ○ No

Name _____Location_____ Phone_____

IMMUNIZATIONS - Please list date of injection ○ None ○ Hep A, adult ____ ○ Hep B, adult ____ ○ Td (adult) ____ ○ PPD ____ ○ Zoster ____ ○ Influenza ____ ○ Pneumonia ____

CURRENT MEDICATIONS – Please include any and all BLOOD THINNING AGENTS!!!

○ I do not take any medications, including over the counter medications.

Drug Name	Strength	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SIGNATURE: _____ **TODAY'S DATE:** _____

Completed by: ○ Patient ○ Parent ○ Guardian