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Venture Gastroenterology, LLC

Patient's Personal History and Health Assessment
Circle all that apply

Patient Name: _____ **PCP:** _____

Medications: List each drug, its amount, and how often you take them.
1.
2.
3.
4.
5.

Medication Allergies: Yes / No
If yes, list medication and the reaction you had with them

Medical Illnesses or Conditions:
Anxiety Disorder | Arthritis | Asthma | COPD | Cancer | Coronary Artery Disease | Depression | Diabetes | Diverticulitis | Fibromyalgia | GERD/Reflux | Gout | Heart Disease | High Cholesterol | HIV | Hypertension | Hyperthyroidism | Hypothyroidism | Kidney Disease | Kidney Stones | Liver Disease | Osteoporosis | Pulmonary Embolism | Stroke | Tuberculosis |
Other _____

Hospitalizations & Operations: List and indicate approximate year.

Social History
Do you smoke? Yes/No When did you stop? _____
Cigarettes | Cigars | Pipe |Chewing tobacco | Snuff
How much do/did you use per day? _____ Number of years? ___ Since age _____
Have you been exposed to secondhand smoke at home or work?

Do you drink alcoholic beverages regularly?
Hard liquor 1-3 oz. per day | Over 3 oz. per day
Beer 1 bottle per day | 2 bottles per day | 3 or more
Wine 1 glass per day | 2 glasses per day | 3 or more
Caffeine intake – Yes/ No | 3 or more cups

Did you, or do you, use marijuana? Yes/No
Have you used cocaine, heroin or other _____

Relationship Status:
Married | Single | Domestic Partner | Civil Union Relationship | Separated | Divorced | Widowed

Living Situation:
Live alone | Live with a spouse or partner | Live with roommates | Live with parents or other family members | Other | Number of dependents at home _____

Religion _____

Education: Grade School | High School | College | Other

Gender Identity:
Male | Female | Transgender F2M | Transgender M2F | Other

Sexual Orientation:
Heterosexual | Bisexual | Gay | Lesbian | Other | Not sure

Main language: English | Spanish | Creole | Other
Need a translator? _____

Do you exercise? Regularly | Occasionally | Rarely

Do you use any community services? (Transportation, Meals on Wheels etc.)

Diet: Regular| Vegetarian | Vegan | Gluten Free | Lactose Free

Are you currently being abused physically, sexually, or emotionally?

Occupation/Work History & Environmental Exposure
What is your current occupation?
Did you previously have a different occupation?
Were you ever exposed to the following? Please check or circle all that apply.
Asbestos |Chronic Fumes | Chronic Dust |Radiation |Toxic Chemicals

Family Health History

	Alive	Dead	Age	Cause of Death
Mother				
Father				
Daughter				
Son				
Sister				
Brother				

Gastroenterology
Lost appetite |Recent weight change |Swallowing problems |*Solids stick* |*Choking* |Food comes out your nose |Heartburn |Ulcer |Nausea |Vomiting |Vomit blood |Diarrhea |Upset stomach (food related) |Constipation |Black bowel movements |Bloody bowel movements | yellow or jaundiced |Cirrhosis | Indigestion | Cramps | Bloating | Fullness |Past Endoscopy | Past Colonoscopy |
Findings: _____

Has anybody ever diagnosed you with any of the following? Peptic Ulcer Disease | Gallstones | Liver Disease | Hepatitis | Cirrhosis | Pancreatitis | Colitis | Diverticulosis | Colon Polyps | Cancer: Stomach, Colon, Liver, Pancreatic | Hemorrhoids

Heart, Blood Vessels
Chest pain (Angina) |Chest pressure |Heart attack |Short of breath at night | Heart murmur |Rapid heartbeat that required treatment |Swollen ankles |Leg cramps at night |Leg cramps when walking |Rheumatic fever | Congenital heart disease

General
Fever |Sweats | Weakness |Fatigue

Lungs
Cough every day |Cough, produce sputum (phlegm) most day's |Blood in your sputum | Pneumonia |Bronchitis |Emphysema |Pleurisy |Tuberculosis |Asthma | Short of breath with activity |Short of breath at rest |Frequent colds

Genitourinary
Frequent urination |Painful urination |Urinate at night | Blood in urine
Genitourinary: Men
Difficulty starting/stopping urination |Sexual performance problems |Elevated prostate blood test (PSA) |Prostate biopsy |Swollen/painful testicle | Do you consistently use contraceptives
Genitourinary: Women
Age started menstruating: |Irregular or painful menstruation | Date of last period _____ |Age stopped menstruating _____ | Painful intercourse | Bleeding following intercourse |Endometriosis | Pregnant now |Birth Control Method _____

Neurological
Headaches | Double vision |Blurred vision |Weakness in extremity | Numbness | Forgetfulness |Confusion

Hematologic
Bruise or bleed easily | Anemic |Take aspirin or nonsteroid anti-inflammatory (Motrin, Advil, Alieve) | Swollen glands

Eyes
Lost vision | Wear glasses | Cataract | Glaucoma

Ears
Lost hearing |Ringing in your ears | Hearing aid

Sinuses
Sinus trouble |Nosebleeds

Mouth
Dental problems |Wear dentures |Sore tongue

Neck
Swollen glands

Breasts

Nipple discharge |Breast lumps |Cystic breast disease |Breast infection |Hormone replacement therapy | Date of last Mammogram _____

Skin
Excessive suns exposure | Blistering/burns |Use sunscreen |Dark or pigmented skin lesion |Dark or pigmented skin lesion removed |Melanoma |Bleeding skin lesion |Psoriasis |Chronic rash |Vitiligo |Birthmark |

Extremities & Back
Arthritis |Back pain |Broken bone |Swollen joints | Joint pain

Activities you find difficult
Bathing | Dressing |Eating |Housekeeping |Using toilet |Walking

Medical Equipment
Do you use a: Cane | Oxygen | Catheter | Walker | Wheelchair | Nebulizer