ALASKA DIGESTIVE & LIVER DISEASE

Patient Medical History Form

Name:_____ DOB:_____ Date:_____

REASON FOR VISIT: _____

CURRENT MEDICATIONS

*if you are providing your own list, circle here: MY MED LIST

Medication Name	Dose	Frequency
1.		
2.		
3.		
4.		

Are you taking any Blood Thinning medications, i.e. Coumadin____Warfarin____Plavix____Xarelto____Effient____Pradaxa____ Eliquis____ Aspirin____ Pletal____ Savaysa____ Other_____

INFECTION HISTORY

*Circle if you currently have or have had:

Hepatitis		HIV/AIDS		MRSA		C.DIFF		TB	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Have you had vaccinations, specify year: Tetanus/T-Dap: _____ Flu:_____ Hepatitis B:_____ Pneumonia:_____ Shingles:_____

CHRONIC ILLNESSES

*Circle if you currently have or have had:

☐ Diabetes	☐ Myocardial Infraction	☐ Seizures
☐ Hypertension	☐ CABG/ Heart Bypass	☐ Crohn's Disease
☐ Heart Disease	☐ Pacemaker/ Defibrillator	☐ Ulcerative Colitis
☐ Cardiac Stents	☐ Sleep Apnea (CPAP)	☐ Reflux
☐ Heart Arrhythmia	☐ Anemia	☐ Blood Clots/ DVT
☐ COPD	☐ Pulmonary Embolus	☐ Asthma
☐ Blood Transfusion	Other:	Other:

Have You Ever Had?

☐ Colon Polyps
☐ Colonoscopy: Year_____
☐ Upper Endoscopy: Year_____
☐ Ulcers
☐ Liver Disease
☐ Pancreatitis
☐ Cancer ***Please Specify Type:_____**

ALLERGIES: Medications, Solutions or Metal

Medication, Solution or Metal Name	Allergic Reaction
1.	
2.	
3.	
4.	

PREVIOUS OPERATIONS/HOSPITALIZATIONS

*Please list:

Type	Year	Reason
1.		
2.		
3.		
4.		

Have you ever had anesthesia complications? No Yes

Please describe if answered Yes: _____

FAMILY HISTORY

Please indicate Relationship (i.e. father): Do you know of any blood relatives who have or have had any of the following?

Crohn's or Ulcerative Colitis	Pancreatitis
Ulcer	Polyps
Liver Disease	Cancer (Specify Type)
Celiac Sprue	Other:

SOCIAL HISTORY

Tobacco Use?	**Drug Use?**	**Alcohol Use?**
☐ Smokeless	☐ Meth	☐ Do you drink
☐ E-Cigarettes	☐ Cocaine	☐ Drinks Per Week_____
☐ Cigarettes (Packs/day) _____	☐ Marijuana	☐ Other_____
☐ Never Smoked	☐ IV Drugs	
☐ Former Smoker (Quit Date)_____	☐ Other_____	

REVIEW OF SYSTEMS

* As you review the following list, please circle ALL which have significantly affected you:

GENERAL
Unexpected Weight Loss
Unexpected Weight Gain
Fever
Fatigue

EYES
Blurred/Double Vision
Glaucoma

EARS, NOSE & THROAT
Hearing Loss
Ringing in Ears
Mouth Sores

CARDIOVASCULAR
Chest Pain
Pacemaker/Defibrillator
Cardiac Valve Disease
Shortness of Breath
Swelling of Ankles
Blood Thinners
Taking Aspirin, Aleve or Advil

RESPIRATORY
Chronic Cough
Coughing up Blood
Wheezing

SKIN
Rash
Itching

HEMATOLOGICAL
Bleeding Tendency
Bruising Tendency
Anemia
Past Transfusion

GASTROINTESTINAL
Poor Appetite
Trouble Swallowing
Heartburn
Nausea
Vomiting
Bloating
Belching
Regurgitation
Constipation
Diarrhea
Abd. Pain
Change in Bowel Habits
Rectal Bleeding
Black Tarry Stool

NEUROLOGIC
Headaches
Seizures
Strokes
Numbness/Tingling

PSYCHIATRIC
Memory Loss
Confusion
Depression

ENDOCRINE
Excessive Thirst Excessive
Heat or Cold Intolerance
Diabetic