Patient History Form

North Shore Gastroenterology & Endoscopy Center, Inc.

Please Use Ink to complete this form

Name-			Sex-	DOB-	Ht-	Wt-
Family Physician-			Referring Dr.-			
Marital status: Married Single Widowed Divorced						
Occupation-		E-mail-				
Race-	Ethnicity: Hispanic non Hispanic			Primary Language-		
Do you smoke? No Yes, PPD____ Quit? _________			Alcohol? No Yes, amount_____________			
Drug Use? No Yes, Quit?_________		Do you drink Caffeine? No Yes, Amount____________				

Personal History (please mark any current and/or past medical conditions)

___Anemia	___Colitis	___Heart Murmur	___Seizures
___Alcoholism	___Colon Polyps	___High Blood Pressure	___Thyroid Problems
___Anxiety	___Depression	___High Cholesterol	___Ulcers
___Arthritis	___Diabetes	___Irregular/Heavy Period	___Glaucoma
___Asthma	___Emphysema	___Kidney	___Rheumatic Fever
___Cancer	___Gallbladder	___Liver	___Other_________
___Sleep Apnea	___Pacemaker	___Heart Stents	__________________

Any Surgery?	
Medications?	**Allergies?**

Family History (Please indicate any family member with any of the following)

Colorectal Cancer______________	Breast Cancer__________________	High Blood Pressure_______
Stomach Cancer_______________	Ovarian Cancer________________	Diabetes_________________
Esophageal Cancer_____________	Uterine Cancer_________________	Crohn's Disease___________
Pancreatic Cancer______________	Liver Disease__________________	Ulcerative Colitis__________
Liver Cancer__________________	Gallstones______________________	Heart Disease_____________
Colon Polyps___________________	Other____	

Review of Symptoms

___Loss of appetite	___Cough	___Indigestion	___Memory Loss
___Fatigue	___Shortness of Breath	___Jaundice	___Paralysis
___Fever	___Abdominal Pain	___Nausea	___Anxiety
___Night Sweats	___Belching	___Vomiting	___Depression
___Weight loss	___Rectal Bleeding	___Excessive Urination	___Excessive Thirst
___Nose bleed	___Constipation	___Arthritis	___Bruising
___Hoarseness/voice change	___Diarrhea	___ Back ache	___Swollen Glands
___Chest pain	___Food sticking when swallowing	___Joint Pain	___Other_____________
___Irregular Heart Beat	___Heartburn	___Skin Rash/Itching	
___Swelling of Ankles	___Hemorrhoids	___Dizziness	

____
Patient signature

____
Physician/Nurse Signature

Date: ____________________