

Patient History Form  
 North Shore Gastroenterology & Endoscopy Center, Inc.  
**Please Use Ink to complete this form**

|                         |  |                     |                |                           |     |
|-------------------------|--|---------------------|----------------|---------------------------|-----|
| Name-                   |  | Sex-                | Age-           | Ht-                       | Wt- |
| Family Physician-       |  |                     | Referring Dr.- |                           |     |
| Marital status: Married |  | Single              | Widowed        | Divorced                  |     |
| Occupation-             |  |                     | E-mail-        |                           |     |
| Race-                   |  | Ethnicity: Hispanic |                | non Hispanic              |     |
| Do you smoke? No        |  | Yes, PPD            |                | Quit? _____               |     |
| Drug Use? No            |  | Yes, Quit? _____    |                | Alcohol? No               |     |
|                         |  |                     |                | Yes, amount _____         |     |
|                         |  |                     |                | 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   | Irregular/Heavy Period | Ulcers           |
| Arthritis  | Diabetes     | Kidney                 | Glaucoma         |
| Asthma     | Emphysema    | Liver                  | Rheumatic Fever  |
| Cancer     | Gallbladder  | Other                  |                  |

**Any Major Surgery?**

|                     |                   |
|---------------------|-------------------|
|                     |                   |
| <b>Medications?</b> | <b>Allergies?</b> |
|                     |                   |

**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 _____       |
| 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:** \_\_\_\_\_