San Diego Digestive Disease Consultants, Inc.

NAME ______________________ DOB ___/___/___ AGE ________ DATE ________

Reason for consultation or visit? ______________________

Name of physician requesting consultation ______________________

PAST SURGICAL HISTORY AND HOSPITALIZATION

Name of Operation or Reason for Hospitalization (excluding Obstetrical Admissions)	Date

OTHER PAST AND PRESENT MEDICAL CONDITIONS OR DISEASES

	Approx. Date of Diagnosis

MEDICATIONS: Please list all your current medications including both prescription drugs and over-the-counter medications (Aspirin, Tylenol, Vitamins, Hormones, Laxatives, etc.)

Name of Medication	Dose	How often taken

ALLERGIES: Are you allergic or sensitive to any medication? No _______ Yes_______. If so, please list them.

Name of medications	Type of Reaction (Hives, Rash, etc.)

Patient's history (above) reviewed by physician ______________________**(initial)** ________ **Date** ________

Form 4A

NAME ______________________________ DOB ___/___/_____ Date __________

Have you taken any antibiotics in the last 3 months? Yes __________ No __________

FAMILY HEALTH HISTORY

RELATION	AGE IF ALIVE	AGE AT DEATH	MEDICAL PROBLEMS and/or CAUSE OF DEATH
Father			
Mother			
Brother			
and / or			
Sisters			
Spouse			
Children			

HAVE ANY BLOOD RELATIVES (excluding yourself) HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	NO	YES	WHICH RELATIVE?
Cancer of the Digestive Organs (stomach, colon, liver, etc.)			
Colon Polyps			
Inflammation of the Bowel (Colitis)			
Liver Problems (yellow jaundice, Hepatitis, Cirrhosis)			
Stomach ulcers			
Trouble with Diarrhea or Constipation			
Gallbladder Disease			
Problems with Alcohol			

SOCIAL HISTORY

Single________ Married _______ Separated _______ Divorced _______ Widowed _______ Domestic Partner _______

Are you Employed? Full time ________ Part time ________ Homemaker ________ Retired ________ Unemployed ______

What is or was your job? ______________________________

Alcoholic Beverages: __________ drinks per day OR __________ drinks per week __________ Rare or None

Do you use Tobacco? No_______ Yes______Cigarettes - _______ packs per day. If you stopped smoking, when did you stop? __________

Patient's history (above) reviewed by physician______________________ (initial)____________Date __________

NAME ______________________ DOB ____________ Date __________

DIETARY HISTORY

Coffee/Tea No__________ cups per day _________ Caffeinated? Yes________ No_________

Do you use Dairy Products (milk, ice cream, cheese, etc.)?

No _________ Daily _________ Occasionally_________ Rarely_________ Glasses of milk per day _________

Do you have any special type of diet?______________________________

Are there any foods which commonly irritate your stomach or "don't agree with you?" If so, what are they? ______________

____

Average number of daily servings of fruits/vegetables ______________________?

SYSTEMS REVIEW (Past and Present)

General

Recent weight change	NO	YES
Recent appetite change?	NO	YES
Are you in poor overall health?	NO	YES
Fever	NO	YES

Skin

Skin Disease	NO	YES

Eyes

Eye Disease	NO	YES
Glaucoma	NO	YES

HENT

Hearing or Ear problems	NO	YES
Headaches	NO	YES

Respiratory

Chronic or frequent cough	NO	YES
Asthma or wheezing	NO	YES
Difficulty breathing	NO	YES
Any trouble with lungs	NO	YES

Cardiovascular

Chest pain or angina pectoris	NO	YES
Difficulty walking two blocks	NO	YES
Heart trouble or heart attacks	NO	YES
High blood pressure	NO	YES
Swelling of hands, feet or ankles	NO	YES
Heart murmur	NO	YES

Endocrine

Thyroid problems	NO	YES
Diabetes	NO	YES

Gastroenterology

Peptic Ulcer (stomach or duodenal)	NO	YES
Vomiting blood or food	NO	YES
Gallbladder Disease or Gallstones	NO	YES
Hepatitis, Jaundice, or Liver trouble	NO	YES
Black stools or rectal bleeding	NO	YES
Hemorrhoids, Fissures or Piles	NO	YES
Recent change of bowel habits	NO	YES
Frequent constipation	NO	YES
Frequent diarrhea	NO	YES
Heartburn or indigestion	NO	YES
Abdominal discomfort or pain	NO	YES
Does food stick in your throat?	NO	YES
Chronic Nausea	NO	YES

Genitourinary

Bladder or Kidney Infection	NO	YES
Blood in urine or kidney stones	NO	YES

Gynecologic

Endometriosis or ovarian cysts	NO	YES

Date of last menstrual period____________________

Musculoskeletal

Arthritis	NO	YES

If so, which joints?____________________

Neuro-Psychiatric

Have you ever been advised to seek

Psychiatric care or counseling	NO	YES
Are you depressed or "blue"?	NO	YES
Nervous, Anxious, or panic attacks	NO	YES

Hematologic

Blood Diseases or Anemia	NO	YES
Problems with bleeding after surgery	NO	YES

Patient's history (above) reviewed by physician______________________ **(initial)**__________**Date** ____________

REORDER# 06-19435