

All Island Gastroenterology & Liver Associates, P.C.

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Diplomates in American Board of Internal Medicine and Gastrointestinal Diseases

PATIENT HISTORY FORM

Name: _____ Date of Birth: _____ Referring MD: _____

STATE YOUR COMPLAINT _____

SIGNS & SYMPTOMS		
1) Blood in stool	[] NO [] YES	Amount: LGE_____ SM_____ How long _____ Color Dark Bright Black
2) Abdominal or rectal pain	[] NO [] YES	How long _____ Type Sharp Dull Colicky Continuous Intermittent
Aggravating factors	_____	
Relieving factors	_____	
3) Nausea	[] NO [] YES	New Medication Yes No
4) Vomiting	[] NO [] YES	Blood_____ Food _____
5) Diarrhea	[] NO [] YES	Blood_____ Mucous _____ Foreign Travel _____
6) Fever	[] NO [] YES	
7) Constipation / Change of Bowel Habit	[] NO [] YES	Describe _____ _____
8) Weight Change	[] NO [] YES	Regular Wt _____ Current Wt _____ Appetite Good___ Poor___
9) Change in Eating Habits	[] NO [] YES	Describe _____ _____
10) Trouble Swallowing	[] NO [] YES	Solids _____ Liquids _____ How long _____
11) Heartburn	[] NO [] YES	How long _____ Progressive _____
12) Alcohol Use	[] NO [] YES	Amount _____ Wine ___ Beer ___ Liquor ___
13) Smoking	Cigarettes _____ Cigar _____ Pipe _____ Tobacco _____ Amount _____	
14) Street Drugs	[] NO [] YES	

15) Stress		<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
16) Past History				
	Parasites	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Diverticulitis	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Irritable Bowel	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Ulcers	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Gallstones	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Hepatitis	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Pancreatitis	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Other (specify)	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	_____

17) Past Surgical History _____				

18) X-Rays				
	Upper GI Series	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	Date _____ Results _____
	Sonogram	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	_____
	Barium Enema	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	_____
19) Endoscopies				
	Gastroscopy	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	Date _____ Results _____
	Colonoscopy	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	_____
	ERCP	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	_____
20) Family Illnesses				
	Ulcer	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	Family member _____
	Cancer	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	Family member _____
	Kind _____	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
21) Medications				
	Laxatives	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Vitamins / Iron	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Aspirin	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Antacids	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Other	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	List _____

22) Blood Transfusions		<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	Date _____
				Reason _____

23) Allergies				
	Drug Allergies	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	List _____
	Latex Allergies	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	
	Other Allergies	<input type="checkbox"/>]NO	<input type="checkbox"/>]YES	List _____

Signature		Date		

