Gastroenterology Associates of West Florida
Digestive Diseases and Nutrition

Social Security Number _____

Patient Health History Form

Please complete this history form while waiting to see your physician. All information is confidential and is helpful in your treatment.

Patient Name: _____ Today's Date: _____
Age: _____ Date of Birth: _____ Last Colonoscopy_____ Last EGD_____ □ **Updated** as of _____

HISTORY OF PRESENT ILLNESS: What is the main reason you are here:

MEDICATIONS List any medications you are taking, doses and frequency

Attached □

ALLERGIES (Food/Environmental/Drug)

Attached □

SYMPTOMS/PROBLEMS Check √ current symptoms you have having

GENERAL □	**HEMATOLOGY** □		☐ Bleeding gums	**WOMEN Only** □
☐ Chills	☐ Bleeding disorders		☐ Hoarseness	☐ Abnormal Pap Smear
☐ Fever	☐ Enlarged lymph nodes		☐ Nosebleeds	☐ Abnormal Vaginal Bleeding
☐ Weight loss	☐ Prior transfusions		☐ Post nasal drip	☐ Breast lump / discharge
☐ Weight gain	**SKIN** □		☐ Ringing in ears	☐ Hot flashes
☐ Weakness	☐ Hair/Nail changes		☐ Voice changes	☐ Vaginal infections
ALLERGY/IMMUNOLOGY □	☐ Itching	☐ Rash	☐ Vertigo	**UROLOGICAL** □
☐ Animal allergy	**GASTROINTESTINAL** □		**CARDIOVASCULAR** □	☐ Blood in urine
☐ Food allergy	☐ Abdominal pain		☐ Chest pain	☐ Difficult urination
☐ Hay fever	☐ Anorexia / Bulimia		☐ Leg pain with exertion	☐ Frequent urination
☐ Hives	☐ Black stools		☐ Palpitations	☐ Loss of urine control
☐ Pollen allergy	☐ Bloody (red) stools		☐ Poor circulation	☐ Painful urination
ENDOCRINE □	☐ Constipation		☐ Rapid heart beat	☐ Sexual dysfunction
☐ Bulging eyes	☐ Difficulty swallowing		☐ Swelling of ankles	☐ Urinary tract infections
☐ Excessive thirst	☐ Loss of bowel control		**MUSCULOSKELETAL** □	**NEUROLOGIC / PSYCH** □
☐ Excessive urination	☐ Jaundice		☐ Fibromyalgia	☐ Fainting
☐ Intolerant heat/cold	☐ Bloating	☐ Gas	☐ Joint Pain	☐ Hallucinations
PULMONARY □	☐ Diarrhea	☐ Heartburn	☐ Muscle Pain	☐ Memory loss
☐ Chronic cough	☐ Nausea	☐ Vomiting	☐	☐ Phobias
☐ Coughing up blood	☐ Painful swallowing		**MEN Only** □	☐ Numbness
☐ Night sweats	☐ Poor Appetite		☐ Erection difficulties	☐ Speech problems
☐ Shortness of breath	☐ Rectal Pain		☐ Lump in testicles	☐ Tremor
☐ Sputum Production	**EYE, EAR, NOSE, THROAT** □		☐ Penis discharge or sores	☐ Weakness
☐ Wheezing	☐ Altered taste		☐	☐