Illinois Gastroenterology Group
IGG

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Patient History Worksheet

Please bring this completed form to your appointment and be prepared to answer these questions.

Name___________________________________ **Date of Birth**________________

Reason for appointment: ____

Current Gastrointestinal complaints:

- ☐ heartburn
- ☐ indigestion
- ☐ regurgitation
- ☐ nausea
- ☐ vomiting
- ☐ lactose/food intolerance
- ☐ rectal bleeding
- ☐ blood on stool/toilet paper
- ☐ rectal pain
- ☐ abdominal pain
- ☐ difficulty swallowing
- ☐ abnormal weight loss
- ☐ diarrhea
- ☐ constipation
- ☐ bloating
- ☐ leaking stools
- ☐ jaundice (yellow skin/eyes)
- ☐ loss of appetite

Allergies: (list all medication, food, IV Dye or latex):

____
____
____

Current Medications: (prescription, over the counter, vitamins—list name and dosage)

____
____
____
____
____
____

Past Medical History:

- ☐ Anemia
- ☐ Arthritis:
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Barretts esophagus
- ☐ Breast cancer
- ☐ Cancer
- ☐ Celiac disease
- ☐ Gall stones
- ☐ Chronic renal failure
- ☐ Cirrhosis:
- ☐ Collagenous colitis
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Congestive Heart Failure
- ☐ COPD (emphysema)
- ☐ Heart Disease
- ☐ Crohn's Disease Colitis
- ☐ Crohn's Disease Ileitis
- ☐ Crohn's Disease Ileocolitis
- ☐ Stroke
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Eosinophilic Esophagitis
- ☐ Gastritis
- ☐ GERD
- ☐ Gout
- ☐ Helicobacter Pylori
- ☐ Hemochromatosis
- ☐ Hemorrhoids
- ☐ Hepatitis:
- ☐ Hiatal Hernia
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypertriglyceridemia
- ☐ Hypothyroidism
- ☐ Irritable bowel syndrome
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver Cancer
- ☐ Liver disease
- ☐ Microscopic colitis
- ☐ Migraine headache
- ☐ Heart attack (MI)
- ☐ Obesity
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Parkinson's disease
- ☐ Stomach ulcers
- ☐ Prostate cancer
- ☐ Prostate hyperplasia, benign
- ☐ Seizure disorder
- ☐ Sleep apnea
- ☐ Thyroid disease
- ☐ Ulcerative colitis pancolitis
- ☐ Ulcerative colitis left sided
- ☐ Ulcerative colitis distal
- ☐ Valvular Heart disease
- ☐ Varicies – esophageal
- ☐ Varicies – gastric

continued on back

 Name: ______________________________

Past Surgical History:

	Year		Year		Year
☐ AAA repair	_____	☐ Colon Resection	_____	☐ Mitral Valve replacement	_____
☐ Angioplasty	_____	☐ Colostomy	_____	☐ Nephrectomy	_____
☐ Aortic Valve Replacement	_____	☐ Coronary Stent	_____	☐ Pacemaker/IACD	_____
☐ AP Resection	_____	☐ Gastric bypass	_____	☐ Prostate biopsy	_____
☐ Appendix	_____	☐ Hartmann Procedure	_____	☐ Rotator cuff repair	_____
☐ Back surgery	_____	☐ Hemorrhoidectomy	_____	☐ Small bowel resection	_____
☐ Bronchoscopy	_____	☐ Hernia repair	_____	☐ Hysterectomy & ovaries	_____
☐ Cataract surgery	_____	☐ Hip replacement	_____	☐ TURP	_____
☐ CABG (heart bypass)	_____	☐ Hysterectomy	_____	☐ Thyroidectomy	_____
☐ Carpal tunnel release	_____	☐ Knee replacement	_____	☐ Vaginal hysterectomy	_____
☐ Cesarean section	_____	☐ Liver biopsy	_____		
☐ Gall Bladder	_____	☐ Lysis of adhesions	_____		
		☐ Mastectomy	_____		

Past Colonoscopy History

Date: ________________ Facility: ______________________________ Results: ___________________

Family History: (list family member and age of onset)

☐ Colon cancer: ____

☐ Colon polyps: ____

☐ Crohn's disease/Ulcerative colitis: ____

Social History:

Tobacco Use:

☐ Never ☐ Former ☐ Current (how much) ______________________

Alcohol Use:

☐ None ☐ Occasional ☐ Moderate ☐ Heavy ☐ Former

Preferred Pharmacy: ____

Other information:

____
____
____
____
____
____
____
____

Thank you for providing this valuable information.