DIGESTIVE HEALTH CENTER OF MICHIGAN

Name: **Date of Birth:** **Date:**

Referring Physician: **Primary Care Physician:**

REASON FOR VISIT:

- ☐ Abdominal Pain
- ☐ Anemia
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Colon Cancer Screen
- ☐ Colon Polyp History
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn / Reflux
- ☐ Trouble swallowing
- ☐ Other: _____

_____

HISTORY OF PRESENT ILLNESS:

Date you first noticed the problem: _____

Have you ever had this type of problem before?: (Please circle) YES NO

What makes your problem better: _____

What makes your problem worse: _____

Does your problem interfere with regular activities? (Please Circle) YES NO

Are you experiencing pain associated with your problem? (Please Circle) YES NO

Location of pain? (Please Circle) UPPER ABDOMEN LOWER ABDOMEN CHEST

Describe your pain: (Please Circle) SHARP DULL CONSTANT INTERMITTENT

Intensity of pain (On a scale from 0-10, {0= No Pain, 10= Worst pain}) : _____

Bowel Habits: _____ per day/per week

Do you have?:

Normal Stools:	☐ Yes	☐ No	Hard Stools:	☐ Yes	☐ No
Blood in Stools:	☐ Yes	☐ No	Mucus in Stools	☐ Yes	☐ No
Black Stools:	☐ Yes	☐ No	Sense of Urgency	☐ Yes	☐ No
Diarrhea:	☐ Yes	☐ No	Thin Caliber:	☐ Yes	☐ No

REVIEW OF SYSTEMS: *(Please check the symptoms you currently have or have had in the past year.)*

General:
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Nervousness
- ☐ Numbness
- ☐ Fatigue

Pulmonary:
- ☐ Wheezing
- ☐ Shortness of breath

Eye, Ear, Nose, Throat:
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Snoring

Genitourinary:
- ☐ Blood in urine
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Painful urination

Cardiovascular:
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles

Gastrointestinal:
- ☐ Belching / Bloating
- ☐ Difficulty swallowing
- ☐ Excessive gas
- ☐ Heartburn
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Weight Loss
- ☐ Yellow jaundice

ALLERGIES: *(Please list any allergies you have. If you don't have any, please write NONE.)*

_____

_____

FAMILY HISTORY:

Any family member with:

Colon Polyps ☐ Yes ☐ No

Colon Cancer ☐ Yes ☐ No

If yes to the above, please list relationship: _____

HOSPITALIZATIONS/SURGERIES:(*Please list illness and/or surgery with the approximate year)*

_____

_____

PAST MEDICAL HISTORY: *Please check any conditions you have or have had in the past.*

☐ AIDS	☐ Bronchitis	☐ Heart Failure	☐ Multiple sclerosis
☐ Alcoholism	☐ Bulimia	☐ Heart Murmur	☐ Pacemaker/ICD
☐ Anemia	☐ Cancer _____(type)	☐ Heart Surgery	☐ Pneumonia
☐ Anorexia	☐ Chemical Dependency	☐ High Cholesterol	☐ Rheumatic Fever
☐ Anxiety	☐ Depression	☐ HIV Positive	☐ Seizures
☐ Appendicitis	☐ Diabetes	☐ Hypertension	☐ Sleep apnea
☐ Artificial heart valve	☐ Emphysema/COPD	☐ Kidney Disease	☐ Stroke/TIA
☐ Asthma	☐ Endometriosis	☐ Kidney Stones	☐ Thyroid problems
☐ Bleeding disorders	☐ Fibromyalgia	☐ Lupus	☐ Tuberculosis
☐ Blood clots	☐ Heart Attack	☐ Migraines	

Other: _____

PREVIOUS GASTROINTESTINAL PROBLEMS:

☐ Achalsia	☐ Esophageal Stricture	☐ Liver Disease
☐ Barrett's Esophagus	☐ Gallstones / Gallbladder Problems	☐ Pancreatitis
☐ Colon Cancer	☐ Gastrointestinal Bleeding	☐ Peptic Ulcer Disease
☐ Colon Polyps	☐ GERD / Reflux	☐ Ulcerative Colitis
☐ Crohn's Disease	☐ Hemorrhoids	☐ Other _____
☐ Diverticulosis	☐ Irritable Bowel / Spastic Colon	_____

PREVIOUS GASTROINTESTINAL EXAMS:

☐ Barium Swallow	☐ CT Scan: _____	☐ Small Bowel Series	☐ Upper GI Series
☐ Capsule Endoscopy	☐ ERCP	☐ Ultrasound: _____	☐ Other: _____
☐ Colonoscopy	☐ MRI: _____	☐ Upper Endoscopy (EGD)	_____

PERSONAL SOCIAL HISTORY:

Do you currently smoke?	☐ Yes	☐ No	If yes, #_____ packs/day for _____ years
Have you ever smoked?	☐ Yes	☐ No	If yes, #_____ years quit
Do you currently use alcohol?	☐ Yes	☐ No	If yes, _____ oz/week, _____beers/week
Have you ever used alcohol?	☐ Yes	☐ No	If yes, #_____ years quit
Do you have daily caffeine intake?	☐ Yes	☐ No	If yes, what is the source and amount of intake? (i.e. coffee, soda, chocolate, tea, diet pills e tc.)_____

FOR WOMEN ONLY:

Are you post menopausal? ☐ Yes ☐ No

If no, when was your last menstrual period? _____

Are you Pregnant? ☐ Yes ☐ No

Are you Nursing? ☐ Yes ☐ No