

# Patient's Personal History

Date: \_\_\_\_\_



**CAPITAL CITY  
GASTROENTEROLOGY, INC.**

4126 Carmichael Court Montgomery, AL 36106 Phone 334-495-2600

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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F Marital Status: S M W D

Person to Notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Their Phone Number: ( ) \_\_\_\_\_

Date of Last Physical Examination: \_\_\_\_\_ Doctor: \_\_\_\_\_

**Family History:**

	If Living			If Deceased	
	Sex	Age	Health	Age at Death	Cause
Father					
Mother					
Brothers/Sisters (circle sex)					
	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Children	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
	M F				

Do you know of any blood relative who has or had: (circle and give relationship)

Colon Polyps \_\_\_\_\_  
 Colitis \_\_\_\_\_  
 Stomach Ulcers \_\_\_\_\_  
 Cancer (Type): \_\_\_\_\_  
     Colon \_\_\_\_\_  
     Breast \_\_\_\_\_  
     Prostate \_\_\_\_\_

High Blood Pressure \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 Heart Attack \_\_\_\_\_  
 Rheumatic Heart Disease \_\_\_\_\_  
 Congenital Heart Disease \_\_\_\_\_  
 Bleeding Tendency \_\_\_\_\_  
 Diabetes \_\_\_\_\_



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List and serious illnesses you have had which did not require hospitalization.

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List and serious injuries or accidents you have had and the year occurred.

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## To be answered by WOMEN only. (circle Yes or No)

- Yes No Are you still having regular monthly menstrual periods?  
Yes No Have you ever had bleeding between your periods?  
Yes No Do you ever have very heavy bleeding with your periods?  
Yes No Do you feel bloated and irritable before your periods?  
Yes No Are you now or have you ever taken birth control pills?  
Yes No Have you ever had a miscarriage?  
Yes No Have you ever had a discharge from the nipple of your breast?  
Yes No Do you have regular PAP smear? When was your last PAP smear? \_\_\_\_\_

How many children have you given birth to? \_\_\_\_\_ How many miscarriages? \_\_\_\_\_

How many stillbirths have you had? \_\_\_\_\_ How many cesarean births? \_\_\_\_\_

How many premature births have you delivered? \_\_\_\_\_

Date of last menstrual period. \_\_\_\_\_

Have you had any pregnancy complications? \_\_\_\_\_

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## To be answered by men and women. (circle Yes or No)

### Headaches

- Yes No Do you have frequent, severe headaches?  
Yes No Do headaches affect your vision?  
Yes No Do headaches occur on one side of your head? Which side? \_\_\_\_\_  
Yes No Do headaches awaken you from sleep?  
Yes No Do headaches feel like a tight hatband?  
Yes No Do your headaches hurt mostly in the back of your head and neck?  
Yes No Does aspirin, acetaminophen, or ibuprophen relieve your headache pain?

### Other problems

- |     |    |   |     |    |                                      |
|-----|----|---|-----|----|--------------------------------------|
| Yes | No | Have you ever fainted?                  | Yes | No | Have you ever had a convulsion?      |
| Yes | No | Have you ever had spells of dizziness?  | Yes | No | Have you ever had double vision?     |
| Yes | No | Have you had weakness in an arm or leg? | Yes | No | Have you ever had pain in your ears? |

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- |     |    |  |     |    |   |
|-----|----|--|-----|----|---|
| Yes | No | Have you ever had ringing in your ears?    | Yes | No | Have you ever had nosebleeds?               |
| Yes | No | Do you frequently have bleeding gums?      | Yes | No | Do you frequently have a sore tongue?       |
| Yes | No | Do you frequently have trouble swallowing? | Yes | No | Do you frequently have nausea and vomiting? |
| Yes | No | Do you frequently have hoarseness?         |     |    |   |

## Have you ever had shortness of breath in the following circumstances?:

- |     |    |                              |     |    |                                  |
|-----|----|------------------------------|-----|----|----------------------------------|
| Yes | No | Doing your usual work?       | Yes | No | That is accompanied by wheezing? |
| Yes | No | Climbing a flight of stairs? | Yes | No | Do you have a chronic cough?     |
| Yes | No | That awakens you at night?   | Yes | No | Have you ever coughed up blood?  |
| Yes | No | That causes you to cough     | Yes | No | Do you cough up much sputum?     |

## Have you ever had chest pain or tightness in the chest that begins:

- |     |    |  |     |    |                               |
|-----|----|--|-----|----|-------------------------------|
| Yes | No | When exerting yourself?                  | Yes | No | And radiates down one arm?    |
| Yes | No | When walking against strong wind?        | Yes | No | And disappears if you rest?   |
| Yes | No | When walking up hill?                    | Yes | No | Or occurs only at rest?       |
| Yes | No | After a heavy meal?                      | Yes | No | When walking fast?            |
| Yes | No | When upset or excited?                   | Yes | No | When walking in cold weather? |
| Yes | No | You are experiencing heart palpitations? |     |    |                               |
- How many pillows do you sleep on? \_\_\_\_\_
- If you experience chest pain, please explain. \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Have you recently had pain in the stomach that:

- |     |    |  |
|-----|----|--|
| Yes | No | Occurs 1-2 hours after a meal?                 |
| Yes | No | Is brought on by eating fried, or gassy foods? |
| Yes | No | Awakens you at night?                          |
| Yes | No | Is relieved by antacids?                       |
| Yes | No | Is relieved with milk or eating?               |
| Yes | No | Occurs while or immediately after eating?      |
| Yes | No | Is relieved by a bowel movement?               |
| Yes | No | Have you had a loss of appetite?               |

If you have had a change in bowel habit recently, answer the following:

- |     |    |  |                     |       |
|-----|----|--|---------------------|-------|
| Yes | No | Crampy pain in the abdomen?            | When or since when? | _____ |
| Yes | No | Alternating diarrhea and constipation? | When or since when? | _____ |
| Yes | No | Pain during or after a bowel movement? | When or since when? | _____ |
| Yes | No | Mucous in your stool?                  | When or since when? | _____ |
| Yes | No | Blood in your stool?                   | When or since when? | _____ |
| Yes | No | Ribbon-like stools?                    | When or since when? | _____ |
| Yes | No | Black stools?                          | When or since when? | _____ |
| Yes | No | Require strong laxatives or enemas?    | When or since when? | _____ |





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