

DIGESTIVE HEALTH CONSULTANTS OF NORTHERN CALIFORNIA

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MEDICAL HISTORY -- Please fill out all three pages, thank you.

1. Your Name: _____ Today's Date _____
2. Referring Physician _____ Other Doctors involved _____
3. Reason for your visit _____

4. List all medications you are currently taking (include any over-the-counter medications and nutritional supplements). Please include the dosage (milligrams, grams, tbsp., tsp., etc) and how often you take them.

	Medicine	Dosage	Frequency		Medicine	Dosage	Frequency
1.				5.			
2.				6.			
3.				7.			
4.				8.			

5. DO YOU HAVE ANY ALLERGIES OR SENSITIVITIES TO MEDICATIONS OR LATEX? YES NO
explain here: _____

6. Do you take products containing aspirin or related medications? (ibuprofen, Advil, Aleve, Alka-Seltzer, Anacin, Bufferin, Excedrin, Midol, Motrin, Naprosyn, other arthritis medication, etc.) _____

7. What is your approximate weight now? ____ One year ago? ____ Five years ago? ____ Height _____

8. Do you now have or have you ever had:

	yes	no	year of onset
Hypertension	()	()	_____
Diabetes	()	()	_____
Heart disease	()	()	_____
Asthma	()	()	_____
Emphysema or COPD	()	()	_____
Hepatitis/Jaundice	()	()	_____
Colitis/Crohn's	()	()	_____
Stroke/TIA	()	()	_____
Problems with Anesthesia	()	()	_____
Sleep Apnea	()	()	_____
Other: _____			_____

9. Please list all prior surgeries you have had:

	Year of surgery	Type of surgery	Hospital	City
A.				
B.				
C.				
D.				
E.				
F.				

9. COLORECTAL CANCER SCREENING: (circle or fill in the blank)

Have you ever had a sigmoidoscopy, colonoscopy, or barium enema (lower GI)? **SIG COLON BE NONE**
 When? _____ What was the result? **NORMAL OTHER** _____

NAME: _____

10. Do you smoke cigarettes? **YES NO** If yes, approximately how much do you smoke per day? _____
If you have quit smoking, when did you quit? _____ How many years have you/did you smoke? _____

11. How many drinks of alcohol do you consume in an average 7 day period of time? (Please count all alcoholic drinks, including beer and wine.) _____

12. How many cups of coffee do you drink per day, on the average? _____

13. Have you ever received a blood transfusion? **YES NO** If yes, when? _____

14. Occupation (if retired; prior occupation) _____
Any Toxic Exposures? _____

15. FAMILY HISTORY

	IF LIVING Age and Health Problems	IF DECEASED Cause of Death
Father	_____	_____
Mother	_____	_____
Spouse	_____	_____
Brother/Sister	_____	_____
	_____	_____
	_____	_____
Children	_____	_____
	_____	_____
	_____	_____
	_____	_____

16. Have any of your close blood relatives ever had stomach cancer, colon cancer, other cancers, celiac disease, heart disease, blood disorders, hemophilia, liver disease, hepatitis, ulcers, or inflammatory bowel disease?
A. _____
B. _____
C. _____
D. _____

If you have any further comments or any particular concerns that you would like to discuss at your appointment, please list them below (or continue on the back of this page, if necessary).

Please complete the final page that follows. Your time and effort completing this form will allow us to provide you with more complete and personalized care. Thank you!

NAME: _____

Review of Systems

SYMPTOM	YES	NO	DETAILS
Fever			
Fatigue/Weakness			
Weight loss			
Weight gain			
Chills			
Sweats			
Loss of appetite			
Sleep disorder			
Nausea			
Vomiting			
Diarrhea			
Constipation			
Abdominal pain			
Abdominal bloating			
Rectal pain			
Blood in stool			
Black stool			
Change in bowel habit			
Trouble swallowing			
Indigestion			
Reflux			
Vomiting			
Chest pain			
Palpitations			
Swelling			
Cough			
Wheezing			
Shortness of breath			
Food allergies			
Rash			
Itching			
Yellow skin/eyes			
Pain with urination			
Blood in urine			
Urine incontinence			
Eye pain			
Double vision			
Hearing loss			
Sore throat			
Hoarseness			
Sinus drainage			
Nosebleeds			
Heat/Cold intolerance			
Excessive thirst/urination			
Abnormal bruising			
Anemia			
Back pain			
Joint pain			
Headache			
Weakness			
Depression			
Anxiety			