

Fresno Gastroenterology

A member of Community Foundation Medical Group & Part of
Santé Health Foundation

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Patient name: _____

DOB: _____

Patient #: _____

Past Medical/Surgical/Social History

Past Medical History. Please check all previous illnesses or conditions below.

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> Immune deficiency |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Back problem | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Myocardial infarction |
| <input type="checkbox"/> Barrett's Esophagus | <input type="checkbox"/> Hemophilia or bleeding disorder | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Prostate disease |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colon polyps | | <input type="checkbox"/> TIA |
| | | <input type="checkbox"/> Other: _____ |

Surgical History. Please check any surgeries you have had and indicate date if known.

- | | | |
|--|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Fracture surgery | <input type="checkbox"/> Small intestine surgery |
| <input type="checkbox"/> Bariatric surgery | <input type="checkbox"/> Gallbladder surgery | <input type="checkbox"/> Spine surgery |
| <input type="checkbox"/> Bladder repair | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Take Down Colostomy |
| <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Colon surgery | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Upper GI endoscopy |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Ovary removal | <input type="checkbox"/> Valve replacement |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Pancreas surgery | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Prostate surgery | <input type="checkbox"/> Other: _____ |

Social History

- Do you smoke? No Yes If yes, how many packs a day? _____
- Do you drink alcohol? No Yes If yes, how much per week? _____
- Do you use smokeless tobacco? No Yes If yes, how much per week? _____
- Have you ever used intravenous drugs? No Yes
- Do you have tattoos? No Yes