Florida Digestive Health Specialists
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GASTROENTEROLOGY
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MEDICAL HISTORY UPDATE

Name: _____ **Date:** _____

Date of Birth: _____ **Reason for Visit:** _____

Since your last visit to our office, your life may have changed and this may affect your health. Please help us to provide the best health care for you by completing this short health history update.

Medication Allergies? _____ **Adverse Reaction?**_____
Name of Primary Physician _____**Last visit** _____
Do you smoke cigarettes? _____**How many per day?** _____
Do you use alcohol or drugs? _____
Please indicate any medical testing you have had since your last visit and when:
X-ray _____ EKG _____
Blood Test _____ Stool for occult blood _____
Other: _____

Circle One		**If yes, please specify:**
Have you changed your occupation?	Y or N	_____
Do you have any problems at home?	Y or N	_____
Are you exercising?	Y or N	_____
Have you had a blood transfusion since last visit?	Y or N	_____
Have you been diagnosed with any of the following since your LAST VISIT:		
A nervous disorder	Y or N	_____
A thyroid problem	Y or N	_____
High blood pressure	Y or N	_____
A heart condition	Y or N	_____
A lung disorder	Y or N	_____
Jaundice, hepatitis or liver disorders	Y or N	_____
Stomach, bowel, or gallbladder	Y or N	_____
Kidney or bladder problems	Y or N	_____
Anemia or blood disorders	Y or N	_____
Diabetes	Y or N	_____
Cancer	Y or N	_____
Have you been hospitalized?	Y or N	When & Why?_____
Have you had recent surgery?	Y or N	_____
Do you have any family history of cancer?	Y or N	_____

* **List Current Medications**:

_____
_____
_____
_____
_____

_____ _____
Patient Signature Date Physician's Signature Date

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