MEDICAL HISTORY FORM

CHAD M. GONZALES, MD / CAROLINE TADROS MD
4403 HARRISON BLVD., SUITE 2855, OGDEN, UTAH 84403
PHONE (801) 387-2550 FAX (801) 387-2555

Name_____ Date of Birth _____ Today's Date _____

Referring M.D._____ Primary Care M.D. _____

REASON FOR VISIT:

DRUG ALLERGIES: (Medication and type of reaction)

CURRENT MEDICATIONS: (Please list tablet size / dosage / over-the-counter / herbal)

PERSONAL MEDICAL HISTORY: (Check if yes, to all that apply)

[ ] Alcoholism	[ ] Crohn's disease	[ ] Heart failure	[ ] Thyroid problem
[ ] Anemia	[ ] Colitis	[ ] Hepatitis	[ ] Tuberculosis
[ ] Angina/heart attack	[ ] Diabetes	[ ] High blood pressure	[ ] Cancer:_____
[ ] Arthritis	[ ] Depression or anxiety	[ ] HIV/AIDS	_____
[ ] Asthma/hay fever	[ ] Emphysema	[ ] Kidney disease	[ ] Venereal disease
[ ] Birth defects	[ ] Epilepsy or seizures	[ ] Liver problems	[ ] Sleep apnea
[ ] Bladder disease	[ ] Glaucoma	[ ] Lung problems	Other _____
[ ] Bleeding disorder	[ ] Headaches	[ ] Stroke	_____

SURGICAL HISTORY: (List all surgeries, type of surgery and when performed)

Check if yes	Year(s)
[ ] Colonoscopy	
[ ] Upper endoscopy	
[ ] ERCP	

FAMILY HISTORY: (Please provide the following information about your parents, siblings and children)

	Age if Living	Health (List significant illnesses)	Age at Death	Cause of death, if deceased
Father				
Mother				
Brothers				
Sisters				
Sons				
Daughters				
Maternal Grandparents				
Paternal Grandparents				

Check if your parents, brothers, sisters, grandparents, aunts, uncles or children have had any of the following:

[ ] Liver Disease/Cirrhosis [ ] Colon Polyps [ ] Ulcerative Colitis [ ] Esophageal Cancer
[ ] Colon Cancer [ ] Stomach Cancer [ ] Crohn's Disease [ ] Celiac Disease/Sprue

SOCIAL HISTORY:

[ ] Single [ ] Married No. of children _____ Occupation_____ _____ Travel (within last 5 yr) [ ] Outside of Utah [ ] Outside of U.S. Location(s) _____	Alcohol use? [ ] Yes [ ] No [ ] Never [ ] Beer [ ] Wine [ ] Liquor No./day _____ No./weekend _____ Starting age _____ Age at quitting _____	Tobacco use? [ ] Yes [ ] No [ ] Never [ ] Cigarettes [ ] Pipe [ ] Chewing tobacco No./day _____ No./weekend _____ Starting age _____ Age at quitting _____	Illicit drug use? [ ] Yes [ ] No [ ] Never Type _____ _____ No./day _____ No./weekend _____ Starting age _____ Age at quitting _____

Do you consume the following?

	Amount per day		Amount per day
Coffee		Non-diet soda pop	
Milk		Diet soda pop	
Tea		Candy	
Fresh fruits		Vegetables	

REVIEW OF SYSTEMS (check if yes, to all that apply) [ ] Check If all other review of systems are negative

Constitutional
[ ] Weight gain
[ ] Weight loss
[ ] Night sweats
[ ] Fever
[ ] Fatigue

Vision
[ ] Vision changes
[ ] Double vision
[ ] Painful/itching eyes

Hearing
[ ] Hearing loss
[ ] Ringing in the ears

Cardiac
[ ] Chest pain/pressure
[ ] Heart palpitations

Respiratory
[ ] Chronic cough
[ ] Wheezing
[ ] Shortness of breath

Psychiatric
[ ] Depression
[ ] Suicidal thoughts
[ ] Anxiety attacks
[ ] Increased stress
Other _____
_____

Gastrointestinal / liver
[ ] Nausea
[ ] Vomiting
[ ] Upper abdominal pain
[ ] Lower abdominal pain
[ ] Heartburn
[ ] Acid reflux
[ ] Difficulty swallowing
[ ] Increased gas and/or bloating
[ ] Loss of appetite
[ ] Fullness with eating
[ ] Vomiting blood
[ ] Blood in the stool
[ ] Leaking stool or accidents
[ ] Mucous in the stool
[ ] Jaundice (yellow skin or eyes)
[ ] Diarrhea
[ ] Constipation
[ ] Gallbladder disease
[ ] Milk intolerance
[ ] Other dietary Intolerance
Other _____
_____

Genitourinary
[ ] Urinary infections
[ ] Blood in urine
[ ] Painful urination

Neurologic
[ ] Headaches
[ ] Abnormal movements
[ ] Numbness
[ ] Abnormal movements

Musculoskeletal
[ ] Weakness arms/legs
[ ] Soreness/cramping

Endocrine
[ ] Hair loss/growth
[ ] Hot flashes
[ ] Heat intolerance
[ ] Cold intolerance
[ ] Breast enlargement

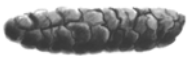
Hematologic / blood
[ ] Bleed/bruise easily
[ ] Blood transfusions

Skin
[ ] Skin itching
[ ] Rash
[ ] Dry skin
Other _____
_____

What type of bowel movement do you have?
(check all that apply)

[ ] 

[ ] 

[ ] 

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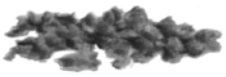
[ ] 

[ ] All liquid

No. stools/day _____
No. stools/week _____

Patient Signature_____ Date _____

MD / PA / NP Signature _____ Date _____