Name:_____

Date of Birth:_____

San Jose Gastroenterology

This is an important documentation of your medical record, please fill in as much and as accurately as you possibly can. Thank you

Past Medical History: (please mark appropriate boxes if yes)

- ☐ Diabetes ☐ Hypertension ☐ High Cholesterol
- ☐ Heart Disease ☐ Arrhythmia ☐ Renal Disease
- ☐ Emphysema/Asthma ☐ Stroke ☐ Liver Disease
- ☐ Other: _____

Past Surgical History: (please mark appropriate boxes if yes)

- ☐ Stomach or intestinal surgeries:_____ ☐ Appendectomy
- ☐ Gallbladder surgery: ☐ Hysterectomy ☐ C-section
- ☐ Heart Surgery: What type?_____ ,when_____
- ☐ Pacemaker Placement ☐ Cardiac cath/Stent
- ☐ Other Surgeries:_____

Medications: Please list all medications that you are currently taking:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Are you currently taking: ☐ Coumadin ☐ Plavix ☐ Aspirin

Allergy to Medications: ☐ NO ☐ YES

If YES, list medications you are allergic to and type of reactions:

_____

Social History:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation:_____ Children:_____ boys _____ girls

Tobacco: ☐ No ☐ Yes How much: for _____ years ☐ Quit – When _____

Alcohol: ☐ No ☐ Yes How much do you drink: _____ ☐ per day, ☐ per week for _____ years. ☐ Quit – When _____

History of blood transfusion, tattoos, IVDA: ☐ No ☐ Yes (circle), When _____

FAMILY HISTORY: (please mark appropriate boxes if yes)

☐ Liver cancer, colon cancer: Who and what type of cancer:_____

☐ Hepatitis B, Who _____ ☐ Hepatitis C, Who _____

Liver diseases, Who_____

Other diseases or cancer: (Diabetes, Liver Diseases, Heart Disease, etc.):

_____

Patient's Signature:_____ Date: _____ Reviewer:_____

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