VIRGIN ISLANDS GASTROENTEROLOGY

PATIENT HISTORY FORM

Patient's Information:

Last Name:	First Name:	MI:	Date of Birth:
Mailing Address:	Social Security#:	Marital Status:	Who lives with you?
Home Phone Number:	Cell Number:	Referring Provider:	Primary Care Physician:
Preferred Pharmacy & location:	Employer:	Occupation:	Work Number:
Insurance Provider:	Insurance Subscriber's Name:	Subscriber's Date of Birth:	Subscriber's Social Security Number:
Emergency Contact Name:	Emergency Contact #:	Relationship to patient:	Preferred Language:

Email Address: _____

Race:

❍ American Indian ❍ Asian ❍ Native Hawaiian ❍ Black or African American ❍ White ❍ Hispanic ❍ Other Race

Ethnicity:

❍ Hispanic ❍ Not Hispanic

Review of Systems:

Please check yes if you (the patient) has ever been diagnosed with any of the following conditions. Is your family physician aware of these conditions? _____ No _____Yes

System	Yes	System	Yes	System	Yes	System	Yes
GASTROINTESTINAL		**CARDIAC**		**NEUROLOGIC**		**EAR, NOSE, THROAT**	
Diarrhea		High Blood Pressure		Seizures		Loose Teeth	
Constipation		Low Blood Pressure		Weakness		Nosebleeds	
Rectal Bleeding		Irregular Heartbeat		Migraines		Deafness	
Change in BMs		Chest Pain		Previous Stroke		**PSYCHOSOCIAL**	
Weight Loss		Cholesterol		**MUSCULOSKELETAL**		Alcoholism	
Polyps		**RESPIRATORY**				Substance Abuse	
Irritable Bowel		Asthma		Muscle Disease		Depression	
Crohn's Disease		Pneumonia		Arthritis		Anxiety Disorder	
Ulcerative Colitis		Bronchitis		Neck Pain			
Trouble Swallowing		Chronic Cough		Back Pain		Lumps	
Nausea/vomiting		Hoarseness		Blood Disorder		Cancer	
Heartburn		Tracheostomy		**SKIN**		Please List Below Any Symptoms or Diseases Not Listed Above:	
Abdominal Pain		**GENITOURINARY**		Rash			
		Kidney Disease		Bruises			
HEPATIC		Frequent Urination		**OPTHALMIC**			
Liver Disease		**ENDOCRINE**		Cataracts			
Hepatitis		Diabetes		Glaucoma			
Pancreatitis		Thyroid Disorders		Blindness			

Past History:

Have you ever had any surgery or been hospitalized? _____ No _____ Yes Have you ever had problems with anesthesia? _____ No _____ Yes	Surgeries	Dates	Hospitalizations other than surgery	Dates

Are you currently or have you ever used any tobacco or alcohol products?	Alcohol: How many drinks per day_____ week_____ month_____ Tobacco: How many packs per day_____ week_____ month_____
Are you using or have you ever used recreational/illicit drugs? _____ No _____ Yes	If yes, what kind? _____ For how long? _____

Are you currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)? _____ No _____ Yes	**Medication**	Dose	Times	**Medication**	Dose	Times

Do you have any allergies (including environmental, medication, food, and reaction to previous drug transfusions)? _____ No _____ Yes
List all in space provided below.

Medication Allergies	Food Allergies	Environmental Allergies	Reaction to Drug Transfusions:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History:

Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:

Condition	Relation to Patient	Condition	Relation to Patient	Condition	Relation to Patient
Colon/ Stomach Cancer o Yes		Ulcerative Colitis o Yes		Crohn's Disease o Yes	
Breast Cancer o Yes		Ovarian Cancer o Yes		Bleeding Problems o Yes	

_____ _____ _____

Signature of Patient or Person Completing the Form | Relationship to Patient | Date

Reviewed by Physician Date (s):