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Loudoun Gastroenterology

Name: Date of Birth: Date:

Current Medications:

Medication Allergies:

Females Only: Number of Pregnancies: Live Births:

Do You Have a History of any of the Following? (Check those that apply):

High Blood Pressure:	Ulcers:	Angina/Heart Pain:
Heart Attack:	Irregular Heartbeat:	Stroke:
Clotting Disorder:	Anemia:	Pneumonia:
Diabetes:	Hiatal Hernia:	Diverticulosis:
Sleep Apnea:	Hepatitis:	Cancer:
Bleeding Tendencies:	Abdominal Pain:	Constipation:
Diarrhea:	Blood in the Stool:	Hemorrhoids:

List Other Medical Conditions:

Personal Habits (Check those that apply):

Smoking/Tobacco: How many per day?:
Alcoholic Beverages: How many per day?: Month?:
Caffeinated Beverages: How many per day?:

Have you had any of the following operations? (Check those that apply):

Gallbladder:	Hysterectomy:	Appendix:	Removal of Ovaries:
Hernia Repair:	Stroke:	Colon Resection:	Heart Bypass:
Heart Valve:	SA		

List other Operations:

Have you had any of the following tests? (Please list approximate date of most recent):

Blood Tests:	Hysterectomy:	Barium Enema:
Upper Endoscopy:	Colonoscopy:	Sigmoidoscopy:

Family History:

	Age if Living	Health/Cause of Death.	Age at Death
Mother			
Father			
Brothers			
Sisters			
Children			