St. George Endoscopy Center **PATIENT MEDICAL HISTORY**

Patient name: **Date:**

Referring or Family Physician: **Date of Birth:**

Briefly describe primary gastrointestinal problems) for which you are seeking medical attention:

Describe any other associated symptoms you have had with the GI problem:

What tests have already been performed related to these problems?

Test Name	Date	Facility test performed

Do you experience any of the following? (please circle yes or no)

Yes/No	NAUSEA	Yes/No	FOOD STICKING IN CHEST
Yes/No	VOMITING	Yes/No	HEARTBURN
Yes/No	BLOATING	Yes/No	INDIGESTION
Yes/No	ABDOMINAL PAIN	Yes/No	YELLOW JAUNDICE
Yes/No	WEIGHT LOSS	Yes/No	INCREASED APPETITE
Yes/No	CHANGE IN BOWEL HABITS	Yes/No	CHEST PAIN
Yes/No	LACK OF CONTROL FOR STOOLS	Yes/No	LOSS OF APPETITE
Yes/No	RECTAL BLEEDING		
Yes/No	INTOLERANCE TO CERTAIN FOODS		
Yes/No	DIARRHEA/CONSTIPATION		

Family History

Relationship	Male/ Female	Living / Deceased (Age)	Disease and/or cause of death
Mother	Female		
Father	Male		
Brothers & Sisters			
Sons & Daughters			

Is there any history in the extended family of: (please circle yes or no)

Yes/No	CANCER	Yes/No	BOWEL PROBLEMS/COLITIS
Yes/No	ULCERS	Yes/No	LONG STANDING ABDOMINAL PAIN
Yes/No	GALLSTONES	Yes/No	LIVER PROBLEMS

Social History:

_____Single ____Married ____Divorced ____Widowed ____Number of Children