Summit Digestive and Liver Disease Specialists

New Patient Medical History

1 S 280 Summit Ave., Court A-1
Oakbrook Terrace, IL 60181

New Patient Data Base

Name: _____ Date: _____

Sex: M ____ F ____ Date of Birth: _____ Phone: _____

Current Problem

What is the main reason for your visit to our clinic?

_____

Past Medical History

Please list physicians that you currently see:

Name: _____ Reason: _____

Name: _____ Reason: _____

Have you ever had any of the following conditions?

Disease/Symptom	No	Yes	When?
Heart Disease (heart attacks, failure, murmurs, irregular beats)			
Rheumatic Fever			
High Blood Pressure			
High Cholesterol			
Anemia or other blood problem			
Lung Disease (asthma, emphysema, tuberculosis)			
Liver Disease (cirrhosis, hepatitis, yellow jaundice)			
Cancer			
Arthritis			
Bleeding Problems			
Diabetes			
Thyroid Disease			
Stomach Problems			
Gall Bladder Problems			
Seizures (epilepsy)			
Strokes or Paralysis			
Psychiatric Problems			
Skin Problems			
Other medical problem:			

Have you ever had any of the following tests?

Test/ Procedure	No	Yes	When?	Results
Stool Tested for Blood				
Colonoscopy				
Lower GI X-ray (Barium Enema)				
Upper Endoscopy (EGD)				
Upper GI X-ray				
Blood Transfusion				

Previous Hospitalizations/Surgeries

Year: _____ Reason: _____

Year: _____ Reason: _____

Year: _____ Reason: _____

Medication or Food Allergies

Are you allergic to any medication or food?

Medication/Food	Symptoms of Allergic Reaction

Current Medications

Please list all medications you currently use. (Include all over the counter medications, antacids, laxatives, birth control pills and vitamins.)

Name of Medication	Dose	Times per day	Length of time taken

Review of Systems

		No	Yes
General	In the past six months, have you lost over 5 pounds unexpectedly?	_____	_____
	Do you have recurrent unexplained fevers?	_____	_____
Eyes	Do you have intermittent loss of vision or double vision?	_____	_____
ENT	Do you have problems with hearing?	_____	_____
	Do you have problems with speech?	_____	_____
Heart	Do you have chest pain that concerns you?	_____	_____
	Are you bothered by dizzy spells?	_____	_____
	Do you have episodes of irregular heart beat?	_____	_____
Gastro	Do you have difficulty swallowing food or liquids?	_____	_____
	Have you noted a recent change of appetite?	_____	_____
	Have you ever vomited blood?	_____	_____
	Do you have abdominal pain that concerns you?	_____	_____
	Have you noted black or tarry bowel movements?	_____	_____
	Have you noted any changes in your bowel habits?	_____	_____
Genitourinary	Do you have discomfort when you urinate?	_____	_____
	Do you get up at night to urinate?	_____	_____
	(females) Do you have any pain, lumps, or discharge in your breasts?	_____	_____
	(females) Do you have any problems with your menstrual periods?	_____	_____
	(females) Have you had a recent mammogram?	_____	_____
	(females) Have you had a recent pap smear?	_____	_____
Skeletal	Do you have any pain or swelling in your joints?	_____	_____
Skin	Do you have any unexplained skin rashes?	_____	_____
	Do you have any moles that are growing or changing?	_____	_____
Neurologic	Have you had any head injury or been knocked unconscious?	_____	_____
	Are you having any weakness or numbness in your arms or legs?	_____	_____
Psychiatric	Are you bothered by depression?	_____	_____
	Do you have any personal problems you would like to discuss?	_____	_____
Endocrine	Have you become unusually thirsty recently?	_____	_____
	Do you sense room temperature differently than others?	_____	_____
Hematologic	Do you tend to bruise or bleed easily?	_____	_____
Immunologic	Do you get recurrent infections requiring antibiotics?	_____	_____

Family History

Does anyone in your family have any of the following conditions?

Condition	No	Yes	Relationship
Asthma			
Heart Disease			
Hypertension			
Stroke			
Cancer			
Colon Polyps			
Stomach Ulcer			
Irritable Bowel			
Liver Disease			
Diabetes			
Epilepsy			
Kidney Disease			
Arthritis			

Social History

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____ Separated _____

Do you have children? No _____ Yes ____ Number of Children _____

Occupation (current or previous): _____

Have you traveled outside the U.S. this past year? No _____ Yes _____ Where? _____

Do you smoke? No _____ Yes _____ Packs per day _____ How long have you smoked? _____

Do you use alcohol? No _____ Yes _____ How many drinks per week? _____ Date of last drink _____

Do you exercise? No _____ Yes _____ What kind? _____ How often? _____

I certify that, to the best of my knowledge, all the information provided above is accurate.

_____ _____

Patient Signature Date