Date:____________________

# GASTROENTEROLOGY ASSOCIATES OF ROCHESTER, LLP

## *MEDICAL HISTORY FORM*

Last Name____________________________ First Name________________________ M.I.______

Birth Date: _________ Occupation: __________ Male___ Female___ Married___ Single___

Have you ever seen: Dr. Pereira? Yes / No Dr. Madan? Yes / No Dr. Strapko? Yes / No

Have you ever had: Flex Sigmoidoscopy? When?__________Where? ______________Dr?____________

Have you ever had: Colonoscopy? When?__________Where? ________________Dr?_______________

Have you ever had: Gastroscopy? When?__________Where? ________________Dr?_______________

Allergy to medicines/latex? Yes / No (please list):____________________________________________

Are you taking any medications? Yes / No **If yes, attach a current medication list including dosages.**

Current complaints / symptoms: __________________________________________________________

_______________________________________________________________________________

Surgeries (what & when):_______________________________________________________________

_______________________________________________________________________________

PLEASE CHECK IF YOU CURRENTLY HAVE OR HAVE EVER HAD THE FOLLOWING:

| | | | |
|---|---|---|---|
| ____Colitis | ____Diabetes | ____High Blood Pressure | ____Sleep Apnea |
| ____Colon Polyps | ____Heart Disease | ____Liver Disease | ____Stomach Ulcers |
| ____Colon Cancer | ____Hepatitis | ____Lung Disease | ____Stroke |
| ____Cancer (type):_______________________ | | ____Seizures | ____Substance Abuse |

**FAMILY HISTORY**: Adopted? Yes / No If not adopted, complete the family information below.

| | Gastrointestinal Problems | Cancer (**Type**)? | If Deceased, Cause? |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Sisters | | | |
| Brothers | | | |

Any other blood relatives with a history of cancer (please list type)? ______________________________

_______________________________________________________________________________

**SOCIAL HISTORY:**

Do you smoke? Yes / No How Much:__________________ How Long:______________

If no, did you ever? Yes / No Quit Date:__________________ Age:______________

Do you drink alcohol? Yes / No How Much:__________________ How Long:______________

If no, did you ever? Yes / No Quit Date:__________________ Age:______________

Date ______________ Signature ____________________________________________

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