ABDUL S. THANNOUN, MD, PA
GASTROENTEROLOGY

NAME **DATE**
(First) (Middle) (Last)

PERSONAL HISTORY		**YES**	**NO**
1.	Have you ever had:		
a.	Heart problem----------	( )	( )
b.	Heart murmur----------	( )	( )
c.	Chest pain----------	( )	( )
d.	Heart attack----------	( )	( )
e.	Heart surgery----------	( )	( )
f.	High blood pressure----------	( )	( )
g.	Vascular disease----------	( )	( )
h.	Stroke----------	( )	( )
i.	Colon polyps----------	( )	( )
j.	Colon cancer----------	( )	( )
k.	Phlebitis----------	( )	( )
l.	Blood clot in the lungs----------	( )	( )
m.	Bronchial asthma----------	( )	( )
n.	Lung disease----------	( )	( )
o.	Liver disease----------	( )	( )
p.	Diverticulosis----------	( )	( )
q.	Rheumatic fever----------	( )	( )
2.	Have you recently had any of the following: If yes, specify:		
a.	Heartburn_____	( )	( )
b.	Difficulty swallowing_____	( )	( )
c.	Stomach ulcers_____	( )	( )
d.	Vomiting blood_____	( )	( )
e.	Diarrhea_____	( )	( )
f.	Constipation_____	( )	( )
g.	Abdominal pain_____	( )	( )
h.	Blood in stools_____	( )	( )
i.	Weight loss_____	( )	( )
j.	Loss of appetite_____	( )	( )

		YES	NO
3.	Have you ever had:		
a.	Thyroid disease----------	( )	( )
b.	Sugar diabetes----------	( )	( )
c.	High blood fats- cholesterol_____triglycerides_____	( )	( )
d.	Stomach(_____)or duodenal(_____)ulcers-------	( )	( )
e.	Gastrointestinal bleeding----------	( )	( )
f.	Diagnosis of hiatus hernia----------	( )	( )
g.	Hepatitis A (___),B (___), or C(___)----------	( )	( )
h.	Gallstones----------	( )	( )
i.	Pancreatitis----------	( )	( )
j.	Urinary infection----------	( )	( )
k.	Kidney disease----------	( )	( )

4. List any serious infections you have had:

_____
_____
_____
_____

5. List any other surgical procedures not previously mentioned.

Procedure	Date

6.	For women:		
a.	Are you pregnant now?	( )	( )
b.	Do you use birth control pills?	( )	( )
c.	Has your uterus been removed?	( )	( )
d.	Have your ovaries been removed?	( )	( )
e.	Date of last menstrual period?	( )	( )
7.	Are you allergic to dye(___) or iodine(___)?	( )	( )

REVIEW OF SYSTEMS:

8.	Have you been awakened from sleep with choking sensations?	( )	( )

		YES	NO
9.	Do you or have you ever had:		
a.	Dizziness----------	( )	( )
b.	Frequent abdominal pain----------	( )	( )
c.	Frequent indigestion----------	( )	( )
d.	Bloody vomitus----------	( )	( )
e.	Black tarry(___)or bloody(___) stools-------	( )	( )
f.	Recent weight loss----------	( )	( )
	If yes, how much in what time frame?_____		
g.	Loss of appetite----------	( )	( )
h.	Dark(___)or bloody(___) urine----------	( )	( )
i.	Bloody sputum----------	( )	( )
10.	Have you ever taken any of the following medications:		
a.	Blood thinning medications----------	( )	( )
b.	Insulin(___) or oral medications for diabetes(___)	( )	( )
c.	Tagamet----------	( )	( )
d.	Aspirin, Advil, Motrin, Aleve or Ibuprofen----	( )	( )
e.	Pepcid----------	( )	( )
f.	Zantac----------	( )	( )
g.	Prilosec----------	( )	( )
h.	Prevacid----------	( )	( )
i.	Thyroid pills----------	( )	( )

SOCIAL HABITS

11.	Do you or did you ever smoke(___)or chew tobacco(___)	( )	( )
	If YES:		
a.	How much:_____		
b.	When did you start;_____		
c.	When did you stop_____		
12.	Do you or did you drink alcohol----------	( )	( )
	If YES:		
a.	How much_____	( )	( )
b.	When did you start_____	( )	( )
c.	When did you stop_____	( )	( )
13.	Do you drink coffee, tea, or caffeine drinks----------	( )	( )
	If yes, how much_____		
14.	Do you or have you ever used Intravenous drugs?	( )	( )
	If YES:		
a.	When did you start?_____		
b.	When did you stop?_____		
15.	Do you have tattoos----------	( )	( )

		YES	NO
16.	Have any of your blood relatives had the following? If yes, specify whom.		
a.	Gallstones----------	( )	( )
b.	Stomach ulcers----------	( )	( )
c.	High blood pressure----------	( )	( )
d.	Diabetes----------	( )	( )
	If yes, who?_____	( )	( )
e.	Thyroid disease----------	( )	( )
	If yes, who?_____		
f.	Cancer----------	( )	( )
	If yes, what type and who?_____ _____ _____		
g.	Stroke----------	( )	( )
	If yes, who?_____		
h.	Tuberculosis----------	( )	( )
	If yes, who?_____		

RELATION	AGE	LIVING	DECEASED	HEALTH STATUS(IF ALIVE or CAUSE OF DEATH if deceased)
Father_____		_____	_____	_____
Mother	___	_____	_____	_____
Brothers	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____
Sisters	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____
Children	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____
	___	_____	_____	_____