UnityPoint Health
St. Luke's Hospital

Gastroenterology
931 8th Avenue, SE
Cedar Rapids, IA 52401
Phone: (319) 366-8695
Fax: (319) 366-0795

Patient No. _____

Date _____

PATIENTS PERSONAL HISTORY

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name	First	Middle	Birth Date	Birth Place

Address	City	State	Zip	Home Phone	Business Phone

Occupation	Medicare No.	Medicaid No.	Sex	Marital Status	Religion

Insurance Company	Insurance No.	M	F

Person to Notify _____ Relationship _____

Address _____ Phone Number _____

Date of Last Physical Examination _____ Doctor _____

Family or Referring Physician _____ Address _____

Hospital Preference: ☐ Mercy ☐ St. Luke's

FAMILY HISTORY			If Living		If Deceased	
	Sex		Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters* *(Circle Sex)*						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				
Husband/Wife						
Sons/Daughters (Circle Sex)*						
	M	F				
	M	F				
	M	F				
	M	F				
	M	F				

** Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter*

Do you have any blood relatives who have had: (Circle and give details)

Colon Cancer or Polyps _____
Cirrhosis of the Liver _____
Colitis or Crohn's Disease _____
Early onset Heart Disease _____
Celiac Sprue _____

PERSONAL HABITS: (Circle)

Yes No Tobacco — Cigarettes ☐ Packs per day_____ Years_____ Quit 19 _____
Pipe ☐ Cigars ☐ Smokeless ☐

Yes No Caffeine — Coffee _____ Cups per Day
Tea _____ Cups per Day
Pop _____ Cans per Day

Yes No Alcohol — Average Daily/Weekly Consumption _____
Previous Heavy Usage Yes No

Yes No IV or Recreational Drugs ☐ Now ☐ Past

MEDICATIONS: Please bring all of your prescription medications with you for all appointments.

Do you routinely use the following nonprescription medications? (If so, please bring these with you)

Yes	No	Aspirin, Ibuprofen, Naproxen, Ketoprofen
Yes	No	Antacids, Cimetidine/Tagamet, Pepcid, Zantac, Axid

Drug allergies and type of reaction (Please list): ☐ Latex Sensitivity

_____

_____

_____

Please list all surgeries and dates:

_____

_____

_____

_____

Please circle all your medical conditions:

		Other (Please List)
High Blood Pressure	Cancer (Type)	_____
Heart Disease/Murmur/Valve Disease	Ulcer	_____
Diabetes	Colitis	_____
Thyroid Disease	Hepatitis/Jaundice	_____
Seizures	Internal Bleeding	_____
Asthma/Emphysema/TB	Stroke	_____
Bleeding Disorder/Easy Bleeding/Bruising	Anemia/Blood Disorder	_____
Kidney Disease	Anxiety/Depression	_____

Have you previously had these tests? (Circle)

Yes	No	UGI Series	Date? _____
Yes	No	LGI/Barium Enema	Date? _____
Yes	No	Endoscopy/Sigmoidoscopy/Colonoscopy	Date? _____
Yes	No	CT Abdomen +/- Abdominal Ultrasound	Date? _____
Yes	No	Recent blood testing	Date? _____ Where? _____

To be answered by WOMEN only:

Date of last menstrual period _____
or year of onset of menopause _____
Do you have heavy vaginal bleeding? **Yes** **No**
Date of last pelvic exam and Pap test _____
Date of last mammography exam _____
Date of last rectal exam _____

To be answered by MEN only:

Yes **No** **prostate trouble**
Date of last rectal exam _____
Date of last PSA test _____

Have you recently experienced: (Circle)

Yes	**No**	**Chest Pain**	**Yes**	**No**	**Bloody/Tarry Stool**
Yes	**No**	**Shortness of Breath**	**Yes**	**No**	**Jaundice**
Yes	**No**	**Abdominal Pain**	**Yes**	**No**	**Fever/Chills**
Yes	**No**	**Heartburn**	**Yes**	**No**	**Weight Loss/Anorexia**
Yes	**No**	**Swallowing Problem**	**Yes**	**No**	**Vomiting/Nausea**
Yes	**No**	**Change in Bowel Habits/Diarrhea/Constipation**	**Yes**	**No**	**Generalized Itching**

Have you ever received a blood transfusion? **Yes** **No** **Date?**_____

Describe briefly the problem for which you have been referred here today: