NORTHEAST GASTROENTEROLOGY ASSOCIATES, P.C.

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PAST MEDICAL HISTORY

NAME: ______________________________ Date of Birth: ____/____/____ Date of Visit: ____/____/____

	You	Family History	Explanation
Epilepsy			
High Blood Pressure			
High Cholesterol			
Lung Disease/Asthma			
Hepatitis/Liver Disease			
Kidney/Bladder Disease			
Cancer-Type			
Polyps			
Diabetes			
Migraines			
Thyroid Disease			
Heart Disease			
U/C or Crohns Disease			
Celiac (Gluten Sensitivity)			

Marital Status: ___Married ___Divorced ___Separated ___Single ___Widowed
____# of Children ____#of Grandchildren
Women Only: _________Last Period __________Last Pap Smear ________ Last Mammogram
Social History: ____
Employment: ____
Do You Now or Have You Ever: Smoked Cigarettes ________Drank Alcohol ________ Used Illegal Street Drugs_______ Type
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MEDICATIONS   ALLERGIES   HOSPITALIZATIONS/SURGERY/ ILLNESS   YEAR