UNIVERSITY OF ALBERTA
FACULTY OF MEDICINE & DENTISTRY
Department of Medicine

Canadian Digestive Health Foundation

Confidential Medical History Form

Please complete this form to the best of your knowledge BEFORE you arrive for your gastroenterology consultation. Please provide this to the doctor upon arrival for your consultation.

Without this form completed your medical information will be incomplete.

Name: ____________________

Address: ____________________

Telephone # Home: ____________ Work: ____________ Cell: ____________

Email Address: ____________________

Date of Birth: ______/_____/______ (Year/Month/Day)

Occupation: ____________________

Referring Doctor's Name: ____________________ City: ____________

Have you been seen by a gastroenterologist in the past? [ ] Yes [ ] No

If yes, name of gastroenterologist: ____________________ City: ____________

Your Personal History

Please list the reason(s) why you are here to see the doctor:

1) ____________________

2) ____________________

3) ____________________

Do you have a good appetite?	[ ] Yes [ ] No
Has there been a change in your appetite?	[ ] Yes [ ] No
What is your approximate weight?	______ kg / lb
Has there been a recent change in your weight?	[ ] Yes [ ] No
Do you have difficulty swallowing?	[ ] Yes [ ] No
Do you get heartburn or indigestion?	[ ] Yes [ ] No
Do you have pain or discomfort in your abdomen?	[ ] Yes [ ] No
Have you experienced nausea or vomiting?	[ ] Yes [ ] No
How often do you have bowel motions?	______ per day
Has there been a recent change in your bowel motions?	[ ] Yes [ ] No
Do you see blood with your bowel motions?	[ ] Yes [ ] No

Do you have diarrhea? [ ] Yes [ ] No

Are you constipated? [ ] Yes [ ] No

Do you require laxatives? [ ] Yes [ ] No

Please list any bowel tests (for example: barium enema, upper GI series, gastroscopy, colonoscopy) you have had in the past two years, please include dates or years performed if you are able to:

____

____

____

Please list any medications you have tried related to your bowels, please include dosages and the duration you were on the medications if you are able to. (Please include over the counter medications and prebiotics if applicable):

____

____

____

Treatment History

Please list any medical problems you have had in the past and the treatment or operation required.

Problem/Condition/Disease **Hospital** **Year** **Treatment**

1) ____

2) ____

3) ____

4) ____

What drugs are you taking? Please include pain killers, arthritis pills, cold pills, hormones, birth control pills, tranquillizers, over the counter medications, vitamins, health foods. (Please list dose, frequency, route, and when this was started)

1) ______________________________________ 5) ______________________________________

2) ______________________________________ 6) ______________________________________

3) ______________________________________ 7) ______________________________________

4) ______________________________________ 8) ______________________________________

Do you have allergies? [ ] Yes [ ] No

If yes, please list below what they are:

____

____

____

Other Diseases

Please indicate if you have had any of the diseases listed below:

Rheumatic Fever	[ ] Yes [ ] No	Jaundice	[ ] Yes [ ] No
Thyroid	[ ] Yes [ ] No	Cholesterol	[ ] Yes [ ] No
Tuberculosis	[ ] Yes [ ] No	Colitis	[ ] Yes [ ] No
Diabetes	[ ] Yes [ ] No	Ulcers	[ ] Yes [ ] No
Arthritis	[ ] Yes [ ] No	Gallstones	[ ] Yes [ ] No
Bronchitis	[ ] Yes [ ] No	Nerves	[ ] Yes [ ] No
High Blood Pressure	[ ] Yes [ ] No	HIV	[ ] Yes [ ] No

Women's Only Section

How many pregnancies have you had? __________

Did you have any complications during your pregnancy (ies) ? [ ] Yes [ ] No

Do you still have your period [ ] Yes [ ] No

If so are they regular? [ ] Yes [ ] No

Have you taken or do you take The Pill? [ ] Yes [ ] No

Please list any other hormone medication your may be on in the place below:

____

____

____

System Inquiry

Do you have a cough? [ ] Yes [ ] No

Do you get chest pain? [ ] Yes [ ] No

Are you more often short of breath than other people your age? [ ] Yes [ ] No

Have you noticed your ankles becoming swollen? [ ] Yes [ ] No

Do you get up most nights to urinate? [ ] Yes [ ] No

Do you have difficulty urinating? [ ] Yes [ ] No

Have you ever noticed a change in how often you urinate? [ ] Yes [ ] No

Have you noticed any change in the color? [ ] Yes [ ] No

Have you noticed any blood in your urine? [ ] Yes [ ] No

Do you get headaches? [ ] Yes [ ] No

Do you have seizures, fainting, or dizzy spells? [ ] Yes [ ] No

Do you have any weakness or difficulty moving your arms and legs? [ ] Yes [ ] No

Do you have any tingling in your arms or legs? [ ] Yes [ ] No

Do you have any pain or stiffness in your joints? [ ] Yes [ ] No

Do you have any skin trouble? [ ] Yes [ ] No

How long does it take for you to fall asleep? ________ mins

Do you wake up too early? [ ] Yes [ ] No

Are you rested after a night's sleep? [ ] Yes [ ] No

Do you cry frequently? [ ] Yes [ ] No

Family History

Please note illnesses that have occurred in your family – pay special attention to cancer, ulcers, colitis history in your family.

Mother ____________________

Father ____________________

Brother(s) ____________________

Sister(s) ____________________

Children ____________________

Husband ____________________

Wife ____________________

Habits

Please note your personal habits below:

Cigarettes (number per day): ____________________

Approximate alcohol intake per week: Beer: __________ Spirits: __________ Wine: __________

Tea (cups per day): __________ Coffee (cups per day) __________

Travel

Have you travelled outside of Canada in the past two years? [ ] Yes [ ] No

If yes, note country visited and date:

1) ____

2) ____

3) ____

4) ____

Immunizations

Please bring an updated list of ALL IMMUNIZATIONS you have received. Each Provincial Public Health service would be able to provide you with a list you received in each province.

You can find a list of the Public Health locations at:

www.albertahealthservices.ca/services.asp?pid=services&rid=5825 or by contacting (78) 408-LINK (5465)

or Toll free at 1-866-408-LINK (5465)

Release of Information:

I ______________________________ give Dr. ____________________’s office at the University of Alberta Division of Gastroenterology, permission to leave messages regarding appointment dates, times and any information pertaining to medical appointments on

____ My answering machine

____ Private voicemail or

____ With a family member

____ By my indicated email

Patient Signature: ______________________ Date: ______________________