LAWRENCE N. GOLDMAN, M.D., PC
VI GASTROENTEROLOGY & LIVER DISEASES

Patient History Form

Last Name	First Name	MI	Date of Birth
Marital Status: Single, Divorced, Married Widow/Widower		Who lives with you?	
Employer	Occupation	What kind of work do you do?	
Primary Care Physicians		Other doctors involved with your care:	

Review of Systems:

Have you or the patient ever been diagnosed with any of the following? If yes, please check any that apply and explain in the space provided. Is your family physician aware of any symptoms/illnesses that you have checked below? _____ Yes _____No

System	No	Yes	System	No	Yes	System	No	Yes	System	No	Yes
GASTROINTESTINAL			CARDIAC			NEUROLOGIC			EAR, NOSE, THROAT		
Diarrhea			High Blood Pressure			Seizures			Loose Teeth		
Constipation			Low Blood Pressure			Weakness			Nosebleeds		
Rectal Bleeding			Irregular Heartbeat			Migranes			Deafness		
Change in BMs			Chest Pain			Previous Stroke			PSYCHOSOCIAL		
Weight Loss			Respiratory			MUSCULOSKELETAL			Alcoholism		
Polyps			Asthma			Muscle Disease			Substance Abuse		
Irritable Bowel			Pneumonia			Arthritis			Depression		
Crohn's Disease			Bronchitis			Neck Pain			Anxiety Disorder		
Ulcerative Colitis			Chronic Cough			Back Pain			Breast		
Trouble Swallowing			Hoarseness			Blood Disorder			Lumps		
Nausea/vomiting			Tracheostomy			Skin			Cancer		
Heartburn			Genitourinary			Rash			Please List Below Any Symptoms Or Diseases Not Listed Above:		
Abdominal Pain			Kidney Disease			Bruises					
HEPATIC			Frequent Urination			OPTHALMIC					
Liver Disease			ENDOCRINE			Cataracts					
Hepatitis			Diabetes			Glaucoma					
Pancreatitis			Thyroid Disorders			Blindness					

Past History:

Have you ever had any surgery or been hospitalized? _____ No _____ Yes Have you ever had problems with anesthesia? _____ No _____ Yes	Surgeries	Dates	Hospitalizations other than surgery	Dates

Are you currently or have you ever used any tobacco or alcohol products?	Alcohol: How many drinks per day_____ week_____ month_____ Tobacco: How many packs per day_____ week_____ month_____
Are you using or have you ever used recreational/illicit drugs? _____ No _____ Yes	If yes, what kind? _____ For how long?_____

Are you currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)? _____ No _____ Yes	Medication	Dose	Times	Medication	Dose	Times

Do you have any allergies (including environmental, medication, food, and reaction to previous drug transfusions)?: _____ No _____ Yes	Please explain any YES answers in this box:

Family History:

Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions:

Condition	Relation to Patient	Condition	Relation to Patient	Condition	Relation to Patient
Colon/ Stomach Cancer _____ No _____ Yes		Ulcerative Colitis _____ No _____ Yes		Crohn's Disease _____ No _____ Yes	
Breast Cancer _____ No _____ Yes		Ovarian Cancer _____ No _____ Yes		Bleeding Problems _____ No _____ Yes	

Signature and date of person completing this form/relationship to patient:

Reviewed by Physician Date (s):