# MIGUEL A. ARENAS MD
# HEALTH HISTORY
(Confidential)

Date_____ Patient Name_____Age_____ Sex _____

DOB_____/_____/_____ WEIGHT: _____ HEIGHT: _____

Primary care physician _____ Referring physician _____

Describe briefly your present medical symptoms : _____

_____

_____

## *PAST MEDICAL HISTORY* *Check (√) conditions you currently have or have had in the past.*

| | | | |
|---|---|---|---|
| ☐ Peptic ulcers | ☐ Liver Disease | ☐ High cholesterol | ☐ Kidney Disease |
| ☐ Gallbladder disease | ☐ Hepatitis B or C | ☐ Asthma | ☐ Stroke |
| ☐ Diverticulosis | ☐ Irregular heart beat | ☐ Emphysema | ☐ Seizures |
| ☐ Colitis | ☐ High blood pressure | ☐ Arthritis | ☐ Chemical Dependency |
| ☐ Colon cancer or polyps | ☐ Heart disease/failure | ☐ Depression | ☐ Psychiatric care |
| ☐ Other cancer | ☐ Heart murmur | ☐ Prostate disease | ☐ Rheumatic fever |
| ☐ Anemia | | ☐ Diabetes Type ___ | ☐ HIV Positive/AIDS |
| ☐ Alcoholism | | | |

## *OTHER SERIOUS ILLNESS/INJURY AND DATES*

| |
|---|
| |
| |

## *HOSPITALIZATIONS OR SURGERIES*

| DATE | REASON | DATE | REASON |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## *PREVIOUS EXAMINATIONS / TESTS*

| PROCEDURE | YEAR RESULTS | PROCEDURE | YEAR RESULTS |
|---|---|---|---|
| Sigmoidoscopy | | Abdomen CT | |
| Colonoscopy | | Abdomen US | |
| Upper endoscopy | | Liver biopsy | |
| HIDA scan | | Upper GI X-ray | |
| Stool test | | Lower GI X-ray | |

**PLEASE SEE OTHER SIDE TO COMPLETE FORM**

## *ALLERGIES* *List drug and other allergies.* *If no known allergies circle: NKDA*

_____

_____

_____

***MEDICATIONS*** ***List medications you are currently taking.*** ***If you take no medications circle NONE***

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***SOCIAL HISTORY*** ***Check box and describe how much.***

| | | | |
|---|---|---|---|
| ☐ Coffee | | ☐ Drugs | |
| ☐ Tobacco | | ☐ Usual Occupation | |
| ☐ Alcohol | | ☐ Exercise | |

Number of children _____ Marital Status: S M W D Other: _____

FEMALE PATIENTS, please circle:

Are you pregnant or planning a pregnancy? Y N Are you on birth control? Y N

***FAMILY HISTORY*** ***Fill in age at diagnosis and cause of death if applicable***

| CONDITION | FATHER | MOTHER | BROTHERS | SISTERS | CHILDREN | GRANDPARENTS |
|---|---|---|---|---|---|---|
| **Alcoholism** | | | | | | |
| **Colon cancer** | | | | | | |
| **Colon polyps** | | | | | | |
| **Esophageal cancer** | | | | | | |
| **Stomach cancer** | | | | | | |
| **Ulcerative colitis** | | | | | | |
| **Crohn's disease** | | | | | | |
| **Liver disease** | | | | | | |
| **Pancreatobiliary** | | | | | | |
| **Deceased / cause** | | | | | | |
| **Other** | | | | | | |

**I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completion of this form.**

**Patient's signature:_____ Date: _____**