

J. GUILLERMO TRABANINO, M.D., P.A.

I. PATIENT'S PERSONAL HISTORY

Name _____ Age _____ Date _____

Occupation _____

Referring Doctor _____

II. Briefly explain the symptoms which caused you to consult a gastroenterologist:

III. G.I. Symptoms

Have you ever had black or tar-like stools?	YES	NO
Are you bothered by abdominal bloating or distention or gas?	YES	NO
Have you noticed any change in your bowel habits?	YES	NO
Do you have loose watery bowel movements?	YES	NO
How many bowel movements per day do you have? _____		
Are you constipated?	YES	NO
Do you regularly use laxatives?	YES	NO
Do you have alternating diarrhea/constipation?	YES	NO
Do you ever have bright red blood in your stools?	YES	NO
Does milk or other dairy products cause any abdominal symptoms or change in bowel habits?	YES	NO
Do you have hemorrhoids?	YES	NO
Do you have pain after defecation?	YES	NO
Do you have, or have you had, gallstones?	YES	NO
Have you had pancreatitis, or inflammation of your pancreas?	YES	NO
Have your stools recently become fatty, greasy, or do they float?	YES	NO
Have you traveled outside the United States within the last year?	YES	NO
If so, where? _____		
Have you had yellow jaundice or hepatitis?	YES	NO
Have you had any persistent itching?	YES	NO
During pregnancy, did you ever have jaundice?	YES	NO
Do you have a good appetite?	YES	NO
Have you lost your appetite?	YES	NO
Has there been any recent nausea or vomiting?	YES	NO
Have you noticed a change in the color of your urine?	YES	NO
Have you had a blood transfusion within the last year?	YES	NO
Do you have liver problems?	YES	NO
Have you lost weight within the last year?	YES	NO
If yes, how many pounds? _____		
Do you have heartburn or indigestion?	YES	NO
Do you have chest pain?	YES	NO
Do you ever wake up at night with stomach acid contents?	YES	NO
Have you had any recent abdominal pain?	YES	NO
Do you have a history of stomach or duodenal ulcers?	YES	NO
Do you regularly use antacids, (Rolaids, Tums or Maalox, etc.)?	YES	NO

Have you ever vomited blood? YES NO
Do you take aspirin or aspirin containing medications? YES NO

IV. PAST MEDICAL HISTORY

Have you had any surgical operations? YES NO
If yes, name type of operation and year _____

Have you had any other major illnesses? YES NO
If yes, describe _____

Have you had any allergic reaction to any drugs? YES NO
If yes, describe _____

V. FAMILY HISTORY – SIGNIFICANT MEDICAL PROBLEMS

Father _____

Mother _____

Brothers/Sisters _____

Husband/Wife _____

Sons/Daughters _____

VI. PERSONAL HABITS

Do you smoke regularly? If yes, for how many years? _____ YES NO

Do you usually drink over 6 cups of coffee per day? YES NO

Do you drink alcohol regularly? YES NO

Do you have difficulty falling asleep? YES NO

Do you take any medications? YES NO

If yes, give name and dose _____

FOR OFFICE USE ONLY:

WT: _____ HT: _____ T: _____ PR: _____ BP _____
