Blair Gastroenterology Family History, Review of Systems

Patient Name:_____DOB:_____ Date:_____

Family History: Please circle and write the **family member** on the line below if there is any family history of the following: (Family history includes daughter, father, brother, sister, mother, son, aunt, granddaughter, grandson, half brother, half sister, maternal and paternal grandmother and grandfather, nephew, niece, uncle, cousin.)

Cancer: Colon cancer, Ovarian cancer, Skin cancer, Breast cancer, Uterine cancer, Stomach cancer, Esophageal cancer, Kidney cancer, Pancreatic cancer

_____

Colon Polyps:

_____

Liver Disease: Hemochromatosis, Cirrhosis, Other

_____

Other: Osteoporosis, anemia, thyroid disease, IBD/Crohn's/Ulcerative Colitis, Celiac disease, rheumatoid arthritis

_____

Review of Systems: Under each category circle any symptom **you** experience or circle none.

General	**Eyes**	**Ear, Nose, Throat**	**Heart**	**Respiratory**	**Urinary**
None	None	None	None	None	None
Fever	Blurry vision	Hearing loss	Chest pain	Cough	Frequency
Chills	Double vision	Dry mouth	Palpitations	Shortness of	Hesitancy
Weight loss	Flashes	Nosebleeds	Swelling	breath	Discharge
Lost appetite	Pain	Hoarseness		Wheezing	Pain
Fatigue					

Musculoskeletal	**Skin**	**Psychiatric**	**Neurologic**	**Endocrine**	**Hematologic**
None	None	None	None	None	None
Joint pain	Rash	Depression	Numbness	Heat intolerance	Anemia
Swelling	Itching	Anxiety	Tingling	Cold intolerance	Bruising
Stiffness	Skin changes	Memory loss	Weakness	Increased thirst	Bleeding
Arthritis	Nodules		Headaches	Increased urination	Swollen
				Weight change	glands

Other
Hemorrhoids
Urinary Incontinence
Fecal Incontinence

Diabetes (Please circle) - Yes No

Please have your medication list ready for the medical assistant.