Harrisburg Gastroenterology, Ltd.

John P. McLaughlin, D.O., F.A.C.G., F.A.C.P.
Kevin C. Westra, D.O., A.G.A.F., F.A.C.P.
Michael A. Veliuona, M.D.
Cortni J.T. Brooks, M.D.
Aaron J. Reiprich, D.O.
Anish G. Mammen, M.D.

Michelle R. Kostelac, MPAS, PA-C
Lisa C. Brenize, MSPAS, PA-C
Miranda J. Felty, MPAS, PA-C
Jessica M. Bell, CRNP

PATIENT HISTORY FORM

Date: _____/_____/_____

Name: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M ❑ Transgender

Appointment Date/Time:

Briefly describe your present symptoms:

CURRENT MEDICATIONS

Please list any medications that you are currently taking.
(Include non-prescription medications, vitamins and supplements):

Name of drug	Dose (Include strength, amount of pills and how often being taken per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	

DRUG ALLERGIES:	REACTION:

Please complete reverse side of form 2/20/20

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Psoriasis
- ❑ Leukemia
- ❑ Cancer (type) _____
- ❑ Sleep apnea
- ❑ Pneumonia
- ❑ Blood Clot, PE /DVT
- ❑ Asthma
- ❑ COPD
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Tuberculosis
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ GERD
- ❑ IBS

- ❑ Angina
- ❑ Heart Disease
- ❑ Pacemaker/Defibrillator
- ❑ Heart Attack
- ❑ Heart murmur
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Gallstones
- ❑ HIV/AIDS
- ❑ Liver Disease

Do you see a cardiologist: yes/no?
If yes, please provide name below:

_____

Have you had a colonoscopy in the past? ❑ Yes ❑ No

If Yes

Approximate Date: _____

Location & Physician:

_____

Other medical diagnosis not listed above:
(Please list):

_____

_____

_____

_____

SURGICAL HISTORY

List any Surgeries you had with approximate date/year

Operation	**Date/Year**

Please bring this form with you when you come for your appointment.
We look forward to seeing you!

_____ _____

Signature of Patient (If minor, signature of **Guardian or Parent**) **Date**

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