



**COMPREHENSIVE
DIGESTIVE
HEALTH**

Comprehensive Digestive Health

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Patient History Form

Dated

Patient's name

Main issue bringing you in today

Name of any gastroenterologists you saw in the past

Have you had any upper or lower endoscopies in the past? If so, when?

Past Medical History (for example, high blood pressure, diabetes, etc.)

Do you smoke? How much and for how long?

Do you drink? How much and for how long?

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Any family members of yours had cancer of the digestive system?

Allergies

Medications

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