Stephen K. Buto, M.D., Inc.
Gastroenterology & Liver Diseases

Queen's POB II
1329 Lusitana Street, Suite 105
Honolulu, HI 96813
Phone: (808) 524-7676

P.F.S. History Form

Date: ___________________________________

Last Name: ______________________________ First Name: ____________________________________ MI: ___

Try your best to fill out this form. Please ask for help if you need it. If there is not enough room, please continue on the last page. This information will help us take better care of you. All information is confidential and cannot be released without your consent. Thank you!

PAST MEDICAL HISTORY

Have you ever been in the hospital or had operations/surgeries? ☐ No

Year	Hospital	Doctor	Reason for Hospitalization/Surgery done:

(Continue on the last page if more space is needed)

Do you have any medical conditions (for example, diabetes, high blood pressure, asthma)? ☐ No

Year of Diagnosis	Condition	Doctor caring for Condition

(Continue on the last page if more space is needed)

Women only: Number of pregnancies: ___ # of Live Births: ___ Date of Last Menses: _______________

Allergies: ☐ None

Drug/Medicine/Food/Chemical	Reaction	Drug/Medicine/Food/Chemical	Reaction

(Continue on the last page if more space is needed)

Medications: ☐ None
(Please include over-the-counter medicines, vitamins, herbs, etc.)

Name	Strength	How Often
Ex. Tagamet	400 mg	2x/day

(Continue on the last page if more space is needed)

FAMILY HISTORY

☐ Adopted, and/or Don't Know

Father: Alive? ☐ No: Age at Death: ___ years. Cause of Death: ________________________________
☐ Yes: Age: ___ years. Health problems/operations: ____________________________

Mother: Alive? ☐ No: Age at Death: ___ years. Cause of Death: ________________________________
☐ Yes: Age: ___ years. Health problems/operations: ____________________________

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Brothers and Sisters

Name	Age	Health Conditions	Living/Deceased

(Continue on the last page if more space is needed)

Children

Name	Age	Health Conditions	Living/Deceased

(Continue on the last page if more space is needed)

Other Relatives (Grandparents, Uncles/Aunts, Cousins, etc.) with a history of GI Conditions (colon cancer, esophageal cancer, stomach cancer, etc.)

Name	Relationship	Age	Health Conditions	Living/Deceased

(Continue on the last page if more space is needed)

SOCIAL HISTORY

Tobacco: ☐ Never Used

Type	First Used (age)	Quantity (ex. 1 pack cigarettes)	How Often

Last date you had a smoke: ____________ If Quit, When: ____________

Alcohol: ☐ Never Used

Type	First Used (age)	Quantity (ex. 1 glass/can/shot)	How Often

Last date you had a drink: ____________ If Quit, When: ____________

Street Drugs: ☐ Never Used

Type	First Used (age)	Quantity (ex. 1 pill/joint/blunt)	How Often

Last date you had street drugs: ____________ If Quit, When: ____________

Past drug or alcohol rehabilitation program: ☐ No ☐ Yes, if so, then
Where: ______________________________ Last Date: ____________

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed
Spouse or Significant Other's Name: ___________________________

Birthplace:
(City/State/Country): ___________________________________

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Past/Present Occupations/Jobs:	From:	Until:

Do you have a Living Will? ☐ No ☐ Yes

SYSTEMS REVIEW

This is in *addition* to the medical history above, or the reason for today's visit. Check all that apply; write comments below if more space needed. ☐ No additional complaints

1. Have you had any: ☐ Fever ☐ Unexplained tiredness/fatigue ☐ Unexplained sweating at night ☐ Chills
2. Change in Weight: ☐ Gain ___ pounds ☐ Loss ___ pounds Over (time span): ____________________
3. Eyes/vision: ______________________________
4. Ears, nose, throat, mouth: ______________________________
5. Heart/circulation: ______________________________
6. Lungs/breathing: ______________________________
7. Gastrointestinal system/digestion: ______________________________
8. Urinary, male or female systems: ______________________________
9. Muscles, joints, bones: ______________________________
10. Skin: ______________________________
11. Neurological system (brain and nerves): ______________________________
12. Psychiatric system/emotions: ______________________________
13. Endocrine system/glands/hormones: ______________________________
14. Blood/lymph systems: ______________________________
15. Allergic and immune systems: ______________________________

Have you ever been tested for TB (PPD or other): ☐ No ☐ Yes, results: ☐ Neg ☐ Pos

Have you ever been tested for AIDS (HIV): ☐ No ☐ Yes, results: ☐ Neg ☐ Pos