SAMPLE MEDICAL HISTORY — GASTROENTEROLOGY

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1 Patient Information

1 PATIENT DETAILS

Name
Tyler J. Abramowitz

Date of Documentation
05/06/2026

DOB / Age / Sex
11/18/1991 | 34M

Provider
Dr. Priya M. Kapoor, MD — Gastroenterology

MRN
GI-2025-7723

CC Chief Concern

1 REASON FOR OBTAINING HISTORY

New patient intake for established diagnosis of Crohn's disease transferring care from out-of-state gastroenterologist following relocation to Chicago. Patient seeking continuity of biologic therapy and updated workup.

H Past Medical & Surgical History

2a PAST MEDICAL HISTORY

1. Crohn's disease (ileocolonic, L3, non-stricturing non-penetrating, B1) — diagnosed age 24 at Johns Hopkins; multiple flares requiring prednisone courses; currently on vedolizumab. 2. Iron deficiency anemia — secondary to GI blood loss; on oral iron supplementation. 3. Anxiety disorder — managed with sertraline. 4. Vitamin D deficiency — corrected with supplementation, currently maintained. 5. Perianal skin tags — no active fistula disease.

2b PAST SURGICAL HISTORY

Appendectomy (2008, laparoscopic). Colonoscopy x4 (most recent 14 months ago, prior institution — mild-moderate ileocolonic disease, no dysplasia). MR enterography (2024) — terminal ileal thickening without fistula or abscess.

M Medications & Allergies

3a CURRENT MEDICATIONS

1. Vedolizumab (Entyvio) 300 mg IV Q8 weeks — last infusion 6 weeks ago. 2. Sertraline 100 mg PO daily. 3. Ferrous sulfate 325 mg PO BID with vitamin C. 4. Vitamin D3 2000 IU PO daily. 5. Loperamide 2 mg PO PRN for loose stools (uses 2–3x/week). 6. Ondansetron 4 mg PO PRN for nausea (rarely used).

3b ALLERGIES

Infliximab — severe infusion reaction (anaphylaxis, 2017). Penicillin — rash (childhood, unconfirmed allergy, never formally tested).

F Family & Social History

4a FAMILY HISTORY

Mother: Ulcerative colitis — managed medically. Maternal aunt: Crohn's disease. Father: Colon polyps, benign adenomas on screening colonoscopy. Paternal grandfather: Colorectal cancer at age 72. No known hereditary colorectal cancer syndromes.

4b SOCIAL HISTORY

Works as a software engineer; fully remote. Lives with partner in Chicago apartment. Non-smoker (never). Social alcohol — 1–2 drinks on weekends. Denies illicit drug use. Exercises 3x/week (cycling). Diet: Low-residue diet during flares, Mediterranean diet at baseline. Has health insurance through employer (Blue Cross Blue Shield — biologic approval process may need re-initiation).

I Immunization & Preventive Screening History

5a IMMUNIZATION HISTORY

COVID-19 — up to date (bivalent booster 2024). Influenza — annual, most recent October 2025. Tdap — updated 2021. Hepatitis B — completed series (confirmed titers immune). Hepatitis A — completed series. Meningococcal — completed college series. Pneumococcal (PCV15 + PPSV23) — completed 2023 due to immunosuppression. VZV — documented immunity (prior infection).

5b PREVENTIVE SCREENINGS

Colorectal cancer surveillance colonoscopy — 14 months ago (mild-moderate disease, no dysplasia; repeat in 1–2 years per IBD protocol). TB screening (QuantiFERON Gold) — negative, 2024. Bone density DEXA — not yet performed; indicated given prolonged steroid history and IBD (order placed today). Skin cancer screening — deferred to PCP. Depression screening (PHQ-9): 6 (mild), on sertraline.

ROS Review of Systems

6 SYSTEM REVIEW

Constitutional: Mild fatigue, no fever. GI: 3–4 loose stools/day at baseline; no active hematochezia; mild crampy lower abdominal pain; no fistula drainage. MSK: Mild arthralgia of bilateral knees, non-erosive. Skin: No active erythema nodosum or pyoderma gangrenosum at this time. Eyes: No active uveitis. Psych: Managed anxiety, no depression exacerbation.

A Assessment

7a KEY CONSIDERATIONS

34-year-old male with ileocolonic Crohn's disease on vedolizumab, transferring care with partial disease control. Key concerns: mild ongoing symptoms suggesting incomplete remission, need for re-authorization of biologic, DEXA scan gap, and penicillin allergy clarification. Iron deficiency anemia secondary to chronic GI inflammation requires monitoring. Family history of colorectal cancer necessitates adherence to IBD surveillance protocol.

P Plan

7b NEXT STEPS

1. Prior authorization for vedolizumab at new institution — urgent initiation. 2. Order fecal calprotectin and CRP to assess inflammatory activity. 3. Schedule colonoscopy with biopsy within 3 months for disease assessment. 4. DEXA scan ordered today. 5. Penicillin allergy referral to allergy/immunology for formal testing. 6. CBC and ferritin recheck — adjust iron supplementation accordingly. 7. Reinforce low-residue diet counseling. 8. IBD nurse coordinator introduced and contact information provided.

F2 Follow-Up

8 REASSESSMENT

When history should be reviewed / updated

Return in 6 weeks after labs result and biologic re-authorization confirmed. Sooner if active flare — defined as >6 stools/day, fever, or significant hematochezia.

TIME DOCUMENTATION & BILLING

Total Time

Counseling Time

E/M Level
99205 — Office visit, new patient, high complexity

Basis
Medical Decision Making — High Complexity

Primary Dx Code
K50.10 — Crohn's disease of large intestine without complications

Secondary Dx Code(s)
D50.9 — Iron deficiency anemia; F41.1 — GAD; Z87.39 — Personal history of GI disease

PROVIDER NAME	CREDENTIALS	DATE & TIME
Dr. Priya M. Kapoor, MD — Gastroenterology	MD — Gastroenterology	05/06/2026