



PATIENT HEALTH HISTORY

Patient name: _____ **Gender:** _____ **Date of birth:** _____ **Age:** _____

This questionnaire will become a confidential part of your medical record. If you do not want to answer a question, leave it blank and discuss it privately with your doctor.

Referring physician: _____

Primary care physician: _____

What are the main reasons for this visit? _____

PATIENT MEDICAL HISTORY (please check conditions you have a history of)

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Cancer (s) _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hemorrhoids | | |

Other:

1. _____
2. _____
3. _____
4. _____

If applicable, what year was your last colonoscopy? _____

PATIENT SURGICAL HISTORY (please list approximate date)

- | | | |
|--|---|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cholecystectomy/ gallbladder | <input type="checkbox"/> Stomach surgery |
| <input type="checkbox"/> Bowel surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tonsillectomy |

Other:

1. _____
2. _____
3. _____
4. _____

SOCIAL HISTORY

Occupation: _____

Marital status: Married Single Widowed Divorced Number of children: _____

What is your smoking status? Never Current Years smoked _____ Quit What year _____

Do you consume alcohol? No Yes How much and for how long? _____

Have you ever used intravenous drugs, received a blood transfusion or had a tattoo? _____

MEDICATIONS

List all medications you are currently taking and all over-the-counter medications, vitamins, and herbs:

MEDICATION	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES(please list / describe)_____

FAMILY HISTORY

List the cause of death and age if applies:

Father _____ Father's Mother _____ Father's Father _____
 Mother _____ Mother's Mother _____ Mother's Father _____

How many sibling(s) do you have? Brothers: _____ living _____ Sisters: _____ living _____

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism/Substance abuse _____ | <input type="checkbox"/> Cirrhosis/Liver disease _____ |
| <input type="checkbox"/> Cancer (colon) _____ | <input type="checkbox"/> Colon polyps _____ |
| <input type="checkbox"/> Cancer (other) _____ | <input type="checkbox"/> Heart disease _____ |

CURRENT MEDICAL CONDITIONS (please check yes or no for any current conditions you're experiencing)

Yes / No

General:

- __ Recent 10 lb weight change
- __ Fevers
- __ Fatigue
- __ Frequent difficulty sleeping

Head and Neck:

- __ Headaches
- __ Dizziness
- __ Difficulty hearing
- __ Mouth sores
- __ Visual changes
- __ Hoarseness
- __ Swollen glands

Respiratory/Lungs:

- __ Persistent cough
- __ Shortness of breath
- __ Coughing up blood
- __ Wheezing
- __ Stop breathing during sleep

Yes / No

Gastrointestinal:

- __ Appetite change
- __ Nausea/vomiting
- __ Heartburn
- __ Difficulty swallowing
- __ Pain with swallowing
- __ Abdominal pain
- __ Diarrhea
- __ Constipation
- __ Vomiting blood
- __ Blood in the stools

Kidney/Bladder:

- __ Kidney/bladder infections
- __ Problems with bladder control
- __ Blood in urine

Musculoskeletal

- __ Numbness or tingling
- __ Trouble with speech
- __ Joint pain
- __ Weakness in arms/legs

Yes / No

Skin/Hair:

- __ Hair loss
- __ Wounds that don't heal
- __ Rash
- __ Jaundice

Psych/Social:

- __ Feeling discourage
- __ High anxiety/stress
- __ Marital or relationship

Heart/vascular:

- __ Chest pain
- __ Irregular heart beat
- __ Ankle swelling

Neurological

- __ Memory loss
- __ TIA
- __ Stroke
- __ Seizure
- __ Gait disturbance

 Date Patient or Responsible Party Signature Physician's Signature Date Reviewed