PATIENT HEALTH HISTORY

Appointment Date_____________

Patient name: ____ **Preferred name:** ___________________________
Date of birth: _________________ **Age:**_________ **Gender:** ______ **Height:**_____________ **Weight:**_______________
Primary physician:______________________________ **Referring physician:**_____________________________________
Pharmacy name and location:____
May we contact your pharmacy for a list of medications? Yes No

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

REASON FOR VISIT (please *briefly* explain the reason for your visit)

____

____

MEDICATIONS AND ALLERGIES (If additional room is needed, please attach a separate piece of paper)

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

MEDICATION	DOSE	FREQUENCY	LAST TIME TAKEN
____________________________	_________	_________________	___________________
____________________________	_________	_________________	___________________
____________________________	_________	_________________	___________________
____________________________	_________	_________________	___________________
____________________________	_________	_________________	___________________
____________________________	_________	_________________	___________________

ALLERGIES: None Latex Iodine Foods Medications **/** Other____

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

	Diabetes – Type?		Headache/Migraine		Colitis or Crohn's
	Thyroid disease		Tuberculosis / TB		Hemorrhoids
	Heart Problems (*Murmur, Angina, Heart Attack, Valve replacement, Irregular Heartbeat, Ankle Swelling, EKG changes*)		Sleep apnea		***Other** Bowel Problems?*
			Hepatitis / Liver disease		Back / Neck Trouble
	Blood clots / Bleeding tendency		Kidney / Prostate / Bladder Problems		TMJ
	High Blood Pressure / Hypertension		Dysphagia		Arthritis
	Stroke		Reflux or GERD		Muscle Disorders / Fibromyalgia
	Seizure		Ulcer / Hiatal or Abdominal Hernia		Cancer – Type:
	Neurological Problems (Numbness)		***Other** Stomach Problems?*		Psychiatric (Depression, anxiety, memory loss)
	Lung Problems (*Asthma, Emphysema, COPD, pneumonia*)		Diverticular disease		Skin Problems (Eczema, fragile)
			Irritable Bowel Syndrome		**Other:**

Any Illness, Cold, Cough or Fever within last week? No Yes ***If yes, what?*** ____________________________
***Women*: Is there a possibility you are pregnant? No Yes Last menstrual period:**_____________________________

PATIENT SURGICAL HISTORY (please list approximate date)

No surgical history

Appendectomy _________ Colectomy ________ Small bowel resection________ Gallbladder ________
Gastric Bypass _________ Hysterectomy _______ Hernia/Reflux repair ________ Cesarean Section ________

Other surgeries: ____
Check if you have had a bad reaction to anesthesia: No Yes *Explain*___________________________
Has a blood relative had a bad reaction to anesthesia: No Yes *Explain* ___________________________

PROCEDURE (for Colonoscopy and Endoscopy procedures only)

Please list the responsible party *staying within the building through the duration of the procedure* and contact information:

Name and relationship: ____ Telephone: ___________________________
Would you like to discuss any concerns or fears regarding this procedure or have special needs or requests? No Yes

SOCIAL HISTORY

Do you have: Durable Power of Attorney Living Will Medical Treatment Plan Organ Donor Card
What is your tobacco status? Never Current Average use_________ Quit Age Stopped _____
Do you consume alcohol? Never Current Average use_________ Quit Age Stopped _____
Have you ever used recreational / IV drugs? No Yes
Do you have a history of addiction? No Yes
Do you have: Braces Bridges Capped Teeth Chipped Teeth False Teeth Loose Teeth Retainers

Please turn the page for additional information ➡

Patient name: ____ **Date of birth:** ______________

SOCIAL HISTORY (CONTINUED)

Do you have any children?	No	Yes	If yes, how many? ___________
Do you have any tattoo(s)?	No	Yes	
Have you ever received a blood transfusion?	No	Yes	
Do you consume caffeine?	No	Yes	
Marital status:	Single	Married	Divorced Widowed

What is your occupation?_____________________________

RECENT SCREENINGS (please list approximate date)

If applicable, what year was your last colonoscopy? _______________ Where? ____________________

If applicable, what year was your last mammogram? _______________

If applicable, what year was your last bone density scan? _______________

If applicable, what year was your last pneumonia vaccine? _______________

When was your last flu vaccine? _______________

FAMILY HISTORY

Please list any ***family members*** diagnosed with the following conditions and at what age:

Father: Living? Y / N *Cause of death*__________ **Mother**: Living? Y / N *Cause of death*__________ Adopted

Colon polyps______________________________________ Cancer (colon)______________________________

Ulcerative Colitis/Crohn's_________________________ Cancer (other)______________________________

GENERAL MEDICAL CONDITIONS (please check yes for any additional conditions you are experiencing)

Constitutional:
Yes
- □ Weight Gain
- □ Fevers
- □ Night sweats
- □ Weight Loss
- □ Fatigue

Head and Neck:
Yes
- □ Hearing deficit
- □ Double vision
- □ Vision loss

Respiratory/Lungs:
Yes
- □ Difficulty breathing
- □ Frequent cough

Cardiovascular:
Yes
- □ Chest pain
- □ Palpitations

Gastrointestinal:
Yes
- □ Abdominal pain
- □ Blood in the stools
- □ Change in bowel habits
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Heartburn
- □ Vomiting blood
- □ Hemorrhoids
- □ Jaundice
- □ Loss of appetite
- □ Mucus in stool
- □ Nausea
- □ Reflux
- □ Vomiting

Kidney/Bladder:
Yes
- □ Blood in urine
- □ Urinary frequency

Metabolic/Endocrine:
Yes
- □ Cold intolerance
- □ Excessive thirst
- □ Heat intolerance

Neurological:
Yes
- □ Dizziness
- □ Headache
- □ Numbness
- □ Tremors
- □ Vertigo

Psychiatric:
Yes
- □ Anxiety
- □ Depression
- □ Increased stress

Skin/Hair:
Yes
- □ Hives
- □ Itching skin
- □ Rash

Musculoskeletal:
Yes
- □ Back pain
- □ Joint pain

Hematologic:
Yes
- □ Anemia
- □ Easy bleeding
- □ Easy bruising

Immunologic:
Yes
- □ Asthma
- □ Food allergies
- □ Immunosuppression
- □ Seasonal allergies

Other conditions not specified:_____________________

________ ______________________________ ____________________ ___________
Date Patient or Legal Guardian Signature Physician's Signature Date Reviewed