Gastroenterology Health Questionnaire:

DATE____/____/____

PATIENT NAME_____ AGE _____ BIRTHDATE____/____/____ MRN #_____

This history form provides us with information to help us meet your healthcare needs; please complete this form answering each question. **This is a confidential part of your medical record and will be kept in this office.**

Referred By: _____

Primary Care Doctor:

_____

Reason for today's visit is:

List OPERATIONS & Year of Procedure:

_____

_____

_____

_____

List MEDICAL History & Year of Diagnosis:

_____

_____

_____

_____

List Current Medications:

PERSONAL and FAMILY HISTORY: Have you or your immediate family (parents, grandparents, brothers, sisters, children or grandchildren) had any of the following:

Condition	YES	NO	You or Family Member Diagnosed
Colon Cancer	☐	☐	
Crohn's Disease	☐	☐	
Ulcerative Colitis	☐	☐	
Liver Disease	☐	☐	
Heart Disease	☐	☐	
Lung Disease	☐	☐	
Thyroid Disease	☐	☐	
Kidney Disease	☐	☐	
Rheumatoid Disease	☐	☐	
High Blood Pressure	☐	☐	
Diabetes	☐	☐	
Other Cancer	☐	☐	

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No Packs per day_____

Do you drink alcohol? ☐ Yes ☐ No Amount_____

Occupation: _____

Married? ☐ Yes ☐ No

Children? ☐ Yes ☐ No Ages?: _____

Medical History: If any of the listed symptoms have been a severe or frequent problem for you, please indicate this by **circling** the appropriate symptom(s): (If not listed, check **YES** & note specific problem)

GENERAL: weight loss or gain, night sweats, fevers, chills? ☐ Yes ☐ No

HEAD: trauma, dizziness, fainting, seizures, headaches? ☐ Yes ☐ No

EYES: vision changes, color blindness, swelling/puffiness under eyes? ☐ Yes ☐ No

EARS, NOSE, THORAT, MOUTH: pain, deafness, discharge, ringing of ears, vertigo, sinus drainage, nose bleeds, hay fever, sore throat, tonsillitis, hoarseness? ☐ Yes ☐ No

CARDIOVASCULAR: palpitations, chest pain, shortness of breath with activity, fatigue, swelling, hands/feet, high blood pressure, heart murmur, heart attack? ☐ Yes ☐ No

RESPIRATORY TRACT: cough, excessvie sputum, asthma, pleurisy? ☐ Yes ☐ No

GASTROINTESTINAL: painful swallowing, nausea, vomiting, indigestion, jaundice, hepatitis, use of laxatives, diarrhea or constipation? ☐ Yes ☐ No

RECTAL: change in bowel habits, bloody/tarry/clay colored stool, hemorrhoids? ☐ Yes ☐ No

GENITOURINARY: kidney/bladder problems, painful or inability to urinate? ☐ Yes ☐ No

MUSCULOSKELETAL: deformities bones/joints, weakness, limited movement? ☐ Yes ☐ No

SKIN: changes in texture/color of skin/moles, hives, rash, itching, scaling, bruising? ☐ Yes ☐ No

BREASTS: trauma, lumps, pain, nipple discharge, infections? ☐ Yes ☐ No

NEUROLOGIC: paralysis, weakness, incoordination, convulsions, numbness/tingling? ☐ Yes ☐ No

PSYCHIATRIC: anxiety, depression, hallucinations, uncontrolled stress, phobias? ☐ Yes ☐ No

ENDOCRINE: excessive thirst, change in appetitie, excessive urination? ☐ Yes ☐ No

HEMATOLOGIC: excessive bleeding/bruising, previous blood transfusions? ☐ Yes ☐ No

IMMUNOLOGIC: immune disorders, HIV, immuno-suppression? ☐ Yes ☐ No

GYNECOLOGIC: (if applicable): irregular menses, menopause, hormone therapy? ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Signature_____ Date _____

Additional Information

I have read the above information and agree with the content or have made changes where necessary:

Physician's Signature_____ Date: _____