Associates *in* Digestive Diseases
— Gastroenterology and Hepatology —

HEALTH HISTORY

Please complete all pages prior to your office visit. Bring them with you or mail them to our office.

NAME: _____**Date of Birth:** _____**Today's Date:** _____

What is the reason for your visit today?

Screening Colonoscopy History of Polyps Reflux Barrett's Esophagus

Active Problem:

_____

How did you hear about our practice? PCP Family Friend Website Insurance Company

MEDICAL HISTORY

Hospitalizations and Surgery – List the year and the reason for hospitalization or the type of surgery performed.

Previous Hospitalization/Surgeries/Serious Illness When?	Hospital, City, State
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had any of the following? (Please circle):

Colon cancer/Polyps	Anemia	Asthma	Diabetes
Reflux	Heart Attack	Emphysema/COPD	High Cholesterol
Ulcers	Angina/Angioplasty	Sleep Apnea	Arthritis
Gallstones	Arrhythmia/Afib	High Blood Pressure	Kidney Disease
Liver Disease	Heart Failure	Stroke/TIA	Thyroid Disease
Cancer: _____		Seizures	Depression

OTHER:_____

_____

SOCIAL HISTORY

Have you ever smoked? Y/N **Are you a current smoker?** Y/N

Cigarettes per day: _____**How long?** _____

Alcohol? Y/N **Drinks per week?** _____

Caffeine? Y/N **Cups of coffee or tea per day?** _____

Drug Use? Y/N **Type and Frequency**_____

FAMILY HISTORY

List your close relatives along with the following information:

	Living/Age	Deceased and Age at Death	Cause of Death or Significant Medical at Death
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Is there a family history of Colon Cancer or polyps? Do any illnesses run in your family? Please specify relation:

_____

Medications: Please list all medications you are currently taking. Include over-the-counter medicines as well as those taken only as needed.

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies – include medicines and other substances. Describe the type of reaction you have. Are you allergic to latex?

Allergy	Reaction
_____	_____
_____	_____
_____	_____

REVIEW OF SYSTEMS
Do you currently have any of the following (please circle):

Constitutional: a) changes in sleep pattern b) chills c) fatigue d) fever e) headache f) night sweats g) pain h) systemic illness i) unexplained weight gain j) unexplained weight loss

Skin: a) changes in nails b) changes in skin color c) dry skin d) hair loss e) hair thinning f) itching g) rash h) scars i) skin lesions j) swelling k) varicose veins

Head: a) blurred vision b) fainting c) head trauma d) seizures e) headache – describe

_____

Eyes: a) diabetic eye disease b) visual blurring c) diminished vision in left/right/both eye(s) d) double vision e) eye pain f) glaucoma g) infection h) itching i) new glasses j) redness k) scotoma/flashing lights

Ears: a) drainage b) earaches c) hearing loss d) ringing

Nose: a) nosebleeds b) congestion c) postnasal drip d) sinus problems

Mouth: a) bleeding gums b) trouble swallowing c) mouth sores d) sore throat e) hoarseness f) voice changes

Cardiac: a) chest pain b) difficulty breathing c) swelling d) painful extremities e) swelling in extremities f) fatigue g) palpitations h) difficulty breathing at night i) fainting j) weight gain

Respiratory: a) chest pain b) cough c) difficulty breathing d) coughing up blood e) dry cough f) difficulty breathing while lying down or sleeping g) cough with phlegm h) wheezing

Gastrointestinal: a) abdominal pain b) change in bowel habits c) early fullness d) heartburn e) difficulty swallowing food f) loss of appetite g) nausea h) vomiting i) perianal itching j) rectal bleeding

Genital/Urinary: a) blood in urine b) burning/painful urination c) frequency d) incontinence e) kidney stones f) sexual difficulties g) straining h) urgency i) UTI

Female: – a) menopause b) post-menopausal bleeding c) excessive bleeding d) vaginal discharge e) pain with periods f) # of pregnancies _____ g) # of births _____

Male: – a) testicle pain b) erectile dysfunction c) testicular masses d) penile lesion or discharge e) prostate enlargement f) weak stream

Musculoskeletal: a) back pain b) difficulty walking c) joint pain d) joint stiffness e) joint swelling f) muscle cramps g) muscle pain h) scoliosis i) weakness of joints j) weakness of muscles

Endocrine: a) cold intolerance b) excessive thirst c) excessive urination d) glucose intolerance e) glandular problems f) heat intolerance g) hormonal problems h) thyroid disease

Heme/Lymph: a) anemia b) bleeding easily c) bruising easily d) delayed wound healing e) enlarged glands f) past transfusion g) phlebitis

Allergy/Immunology: a) autoimmune disease b) environmental allergies c) frequent illness d) immunodeficiency e) immunosuppression f) seasonal allergies

Neurologic: a) balance difficulty b) concussion c) convulsions d) dizziness e) frequent illness f) gait disturbance g) memory loss h) numbness i) paralysis j) rigidity k) stroke l) tingling sensation m) tremor n) vertigo/spinning

Psychiatric: a) anxiety b) confusion c) depression d) memory loss e) nervousness f) sleep problems g) thoughts or plans of hurting yourself

If you have circled any of the above, please provide more details if necessary:

 # details (frequency, duration, severity, etc…)

____ _____

____ _____

____ _____

____ _____

____ _____