Please bring this form with you on your appointment date:	Arrival:

Digestive Health Specialists
Health History Questionnaire

Name (First, MI, Last)	☐ Male ☐ Female	Date of Birth:
Primary Care Provider:	Referring Provider:	
Preferred Pharmacy and Location:	Pharmacy Phone Number:	
Reason for Visit & Problems:		

Medications
(Including over the counter medications) Please list all medications and/or bring a list with you.

Do you use any of the following?

YES	Medication Name	Strength of each dose?	How many times per day?
☐	**NO MEDICATIONS**		
☐	Blood Thinners (Coumadin/Warfarin/Plavix)		
☐	Oral Steroids		
☐	Iron		
☐	Laxative		
☐	Aspirin, Aleve or Excedrin		
☐	Ibuprofen (Advil,Motrin)		
☐	Tylenol (Acetaminophen)		
☐	Vitamins / Herbal Medications		
☐	Other Non-Prescription Drugs	(Please list below)	

Medication Name	Strength of each dose?	How many times per day?

Allergies: Do you have any allergies? Please list medication and reaction.

☐ NO KNOWN ALLERGIES

Are you allergic to Latex? ☐ YES

Medication	Reaction

☐ No Diagnostic History	**Diagnostic Procedure History**		
☐ Abdominal/Pelvic Cat Scan	Month/Year:	☐ ERCP (endoscopic evaluation of the bile ducts)	Month/Year:
☐ Abdominal/Pelvic Ultrasound	Month/Year:	☐ Sigmoidoscopy	Month/Year:
☐ Barium Enema	Month/Year:	☐ Upper Endoscopy (EGD)	Month/Year:
☐ Colonoscopy	Month/Year:	☐ MRI - Abdominal	Month/Year:
☐ Virtual Colonoscopy/CT	Month/Year:	☐ MRCP - Abdominal	Month/Year:

☐ No Family History	**Family History (Blood Relative)**		
☐ Family History Unknown			
Colon Cancer	☐ Yes	☐ No	Relation:
Colon Polyps	☐ Yes	☐ No	Relation:
Crohn's Disease Ulcerative Colitis	☐ Yes	☐ No	Relation:
Liver Disease	☐ Yes	☐ No	Relation:
Gallbladder Disease	☐ Yes	☐ No	Relation:
Celiac Disease (gluten intolerance)	☐ Yes	☐ No	Relation:
Heart Disease	☐ Yes	☐ No	
Hypertension	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	

Problem List / Medical History: Please check all that pertain to yourself			
☐ Alcoholism	☐ Diabetes	☐ Home Oxygen	☐ Sleep Apnea
☐ Anemia	☐ Diverticulosis	☐ Hypertension	☐ Stroke or CVA
☐ Arthritis	☐ Gallstones	☐ Liver Disease or Hepatitis	☐ Thyroid Disease
☐ Asthma	☐ Gastric or Duodenal Ulcer	☐ Lung Disease/Breathing Difficulties	☐ Tobacco Use
☐ Barrett's Esophagus	☐ H.Pylori Infection	☐ Osteoporosis	☐ Ulcerative Colitis or Crohn's
☐ Blood Transfusion	☐ Heart Attack	☐ Pacemaker/Defibrillator	
☐ Cancer Type:	☐ Heart Failure	☐ Pancreatitis	
☐ Colon or Rectal Polyps	☐ Heart Valve Replacement	☐ Reflux - GERD	
☐ Depression	☐ HIV/AIDS	☐ Seizures	
Are you pregnant ☐ Yes ☐ No ☐ Uncertain			

Social History

Occupation:

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Alcohol	☐ None ☐ Recovering Alcoholic				
	☐ Yes Drinks per week:_____ ☐Beer ☐ Wine ☐ Liquor	How often? ☐ Occasional ☐ Moderate ☐ Heavy ☐ Social ☐ Seldom			
Tobacco	Do you use Tobacco?	☐ Yes	☐ No	☐ Quit Year___	
	If yes, please select type of Tobacco use.	☐ Cigarettes ___ # per day	☐ Chew ___ # per day	☐ Pipe ___ # per day	☐ Cigars ___ # per day
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No If yes, please list type of drug _____ How often? _____ Have you ever given yourself non-prescribed drugs with a needle? ☐ Yes ☐ No				

Surgical History			
☐ NO SURGICAL HISTORY		☐ Hernia Repair	Month/Year:
☐ Abdominal	Month/Year:	☐ Hysterectomy	Month/Year:
☐ Appendectomy	Month/Year:	☐ Abdominal ☐ Vaginal	
☐ Colectomy	Month/Year:	☐ Ileostomy	Month/Year:
☐ Colon Resection	Month/Year:	☐ Laparoscopy	Month/Year:
☐ Gallbladder	Month/Year:	☐ Liver	Month/Year:
☐ Gastric Band	Month/Year:	☐ Lung	Month/Year:
☐ Gastric Bypass	Month/Year:	☐ Pancreatic	Month/Year:
☐ Heart	Month/Year:		

Changes in health in the past year (Please check only those items which apply)

CARDIOVASCULAR	EYES	☐ Vomiting	☐ Loss of Consciousness
☐ Chest Pain	☐ Glaucoma	☐ Vomiting of Blood	☐ Migraines
☐ Irregular Heartbeat	☐ Blurred Vision	GENITOURINARY	☐ Memory Loss
☐ Abnormal Swelling legs/feet	GASTROINTESTINAL	☐ Blood in Urine	☐ Stroke
GENERAL	☐ Abdominal Pain	☐ Kidney Stones	☐ Tingling/Numbness
☐ Weight Loss ____lbs	☐ Black Stools	☐ Low Urine Output	☐ Seizures
☐ Weight Gain ____lbs	☐ Bloating	☐ Painful Urination	PSYCHOLOGICAL
☐ Fevers	☐ Blood in Stool	☐ Pus/Discharge in Urine	☐ Anxiety
☐ Chills/Sweats	☐ Constipation	HEME/LYMPH	☐ Depression
ENDOCRINE	☐ Cramps	☐ Anemia	RESPIRATORY
☐ Excessive Thirst	☐ Decreased Appetite	☐ Easy/Increased Bruising	☐ Trouble Breathing
☐ Excessive Urination	☐ Diarrhea	☐ Enlarged/Swollen Glands	☐ Persistent Cough
☐ Intolerance to Cold	☐ Difficulty in Swallowing	☐ Increased Bleeding	☐ Coughing up Blood
☐ Intolerance to Heat	☐ Gas	MUSCULOSKELETAL	☐ Coughing up Sputum
EAR-NOSE-THROAT	☐ Heartburn	☐ Muscle Weakness	☐ Asthma
☐ Sinus Problems	☐ Leakage of Stool	Pain ☐ Neck ☐ Back ☐ Joints	☐ Wheezing
☐ Hoarseness	☐ Milk/Dairy Intolerance	Stiffness ☐ Neck ☐ Back ☐ Joints	☐ Shortness of Breath
☐ Sore Throat	☐ Mucus in Stool	NEUROLOGICAL	SKIN
☐ Nose Bleeds	☐ Nausea	☐ Dizziness	☐ Skin Rashes
	☐ Rectal Pain	☐ Headaches	☐ Jaundice (yellow skin or eyes)

Thank you for your time. This information will assist us to help you. Remember to bring this form to your appointment. Please feel free to call if you have questions.

Patient Signature: _____ **Date:** _____