

HEALTH HISTORY-TO BE COMPLETED BY PATIENT

Name: _____ DOB: _____ Date: _____
Please Print

REASON FOR VISIT: _____

PRIMARY CARE DOCTOR: _____

Medical Problems- Please indicate if you are ***currently*** experiencing any of the following:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Hepatitis – Type _____ | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Pancreatitis | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Parkinson's disease | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Seizure | |
| <input type="checkbox"/> Chronic lung disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Stomach/duodenal ulcer | |
| <input type="checkbox"/> Cirrhosis of the liver | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Kidney disease/failure | <input type="checkbox"/> Stroke/paralysis | |

Surgeries/Procedures- Please indicate if you have ***previously*** had a surgery or procedure:

- | | | |
|--|--|--|
| <input type="checkbox"/> <i>NONE</i> | <input type="checkbox"/> <i>Endoscopy (EGD)</i> – Date: _____ | <input type="checkbox"/> Obesity surgery |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Esophageal Manometry/pH study | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Breast surgery-KIND: _____ | <input type="checkbox"/> Gallbladder surgery | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Cardiac surgery | <input type="checkbox"/> Hiatal hernia surgery | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Colon resection | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> <i>Colonoscopy</i> – Date: _____ | <input type="checkbox"/> Liver biopsy | |

Social History:

Marital Status: Single Married Divorced Widow

Current Occupation: _____ Employer: _____

Do you currently smoke? _____ If you've smoked previously, when did you stop? _____

How many packs per day? _____ For how many years? _____

Do you drink alcohol? _____ How many drinks per day? _____ per week? _____ per month? _____

Do you use illicit drugs? _____ If yes, what kind? _____

Family History:

History of Heart Disease (heart attack, heart failure)? Yes No who: _____

History of Strokes? Yes No who: _____

History of High blood pressure? Yes No who: _____

History of Diabetes? Yes No who: _____

History of Cancer? Yes No Type: _____ who: _____

History of Crohn's disease or ulcerative colitis? Yes No who: _____

Other: _____

(OVER)