Please answer all questions in full

Today's Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First)*: ¨ M ¨ F	**DOB:**

PERSONAL HEALTH HISTORY

List any medical problems that have been diagnosed and when you were diagnosed, if known

Please list major surgeries

Type	Year	Type	Year

Other hospitalizations

Reason	Year

List your prescribed drugs and over-the-counter drugs, such as vitamins

Name	Strength	How often	Name	Strength	How often

Allergies to medications

Name of medication	Reaction You Had	Name of Medication	Reaction you had

HEALTH HABITS AND PERSONAL SAFETY

GI history	¨ Please check here if you have ever seen a Gastroenterologist before. If so, who?		
	Have you ever had an upper endoscopy or colonoscopy before? ¨ Yes ¨ No If so, when?		
	Does anyone in your family have a history of colon cancer or colon polyps? ¨ Yes ¨ No If so, who and at what age?		
Diet	Are you dieting? If so, type of Diet	¨ Yes	¨ No
Alcohol	Do you drink alcohol?	¨ Yes	¨ No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	¨ Yes	¨ No
	Have you considered stopping?	¨ Yes	¨ No
Tobacco	Do you use tobacco or tobacco products?	¨ Yes	¨ No
	Cigarettes/day?	# of years?	Year quit if applicable?
Drugs	Do you currently use recreational or street drugs?	¨ Yes	¨ No
	Have you ever given yourself street drugs with a needle?	¨ Yes	¨ No
Sex	Are you sexually active?	¨ Yes	¨ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Sibling	¨ M ¨ F	
	¨ M ¨ F	
	¨ M ¨ F	

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

¨ Skin	¨ Chest/Heart	¨ Recent changes in:
¨ Head/Neck	¨ Back	¨ Weight
¨ Ears	¨ Intestinal	¨ Energy level
¨ Nose	¨ Bladder	¨ Ability to sleep
¨ Throat	¨ Bowel	¨ Other pain/discomfort:
¨ Lungs	¨ Circulation	