DIGESTIVE DISEASE SPECIALISTS, P.C.

PATIENT HEALTH HISTORY FORM

Patient name: _____ DOB _____ Age_____

Referring Physician: _____ Primary Care Physician: _____

Height_____ Weight_____

Are you having any of the following symptoms?

YES **NO**

Y N Difficulty when swallowing (food sticking)? If yes, swallowing what ? (pills only, solids, liquids)

Y N Heartburn? Better on meds?_____How long overall have you had this?_____

Y N Nausea ? associated with what other symptoms?_____ Do you have vomiting?_____

Y N Abdominal pain or distress For how long?_____

Where is it located:_____ How long does it last?_____

What makes the pain better?_____ What makes the pain worse?_____

Y N Is pain **aggravated** or **relieved** by bowel movements? (circle what applies)

How frequently do you have bowel movements?_____

Y N Do you have hard stools? Is this a change for you?_____

Y N Loose or watery stools? For how long?_____

Y N Do you pass stool when you don't want to?

Y N Do you have bowel movements that awaken you from sleep?

Y N Have you seen blood in your stools? What color?_____ For how long?_____

Y N Rectal pain?

Other GI history:

Y N Have you had an upper endoscopy (EGD)? If yes, place and date? _____

Y N Have you had a Colonoscopy? If yes, place and date? _____ _____

Y N Have you had previous CT/MRI/Ultrasound of the GI tract? If yes, place and date?_____

Have you been diagnosed with any of the following GI conditions? Circle all that apply

GERD/reflux	Constipation	Gallstones	Hepatitis
Barrett's esophagus	Diverticulosis	Pancreatitis	Fatty Liver
Colon polyps	Diverticulitis	Crohn's Disease	Cirrhosis
Colon cancer	Anal cancer	Ulcerative Colitis	Liver CA
Ulcers	Esophageal stricture	Hemorrhoids	Irritable bowel syndrome
Other:			

Social History:

Do you smoke cigarettes? _____ If yes, I smoke _____ packs per day and have been smoking for _____ years.

If you smoked in the past, when did you quit? _____

Do you drink alcohol? Yes No How much and how often do you drink alcohol? _____

Please turn over to Page 2

Digestive Disease Specialists P.C. PATIENT HEALTH HISTORY FORM (page 2)

Vaccinations: ☐ Influenza_____ ☐ Pneumococcal _____
Date Given Date Given

Where Vaccination (s) administered? _____

List all operations/surgeries below:

Type and reason:	**Year**	**Surgeon**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you EVER been treated for any of the following: Circle all that apply

Asthma	COPD/emphysema	Heart disease/heart attack	Irregular heart rhythm
Stroke	Blood clots	High blood pressure	High cholesterol
Sleep apnea	Seizures	Kidney disease	Thyroid disease
Osteoporosis	Endometriosis	Fibromyalgia	Arthritis
Diabetes Mellitus	**Cancer**, if so, what type**:**		
Other:			

Family history of GI problems: ☐ Unknown as I am adopted ☐ None known

	Relation to you	**Age at diagnosis**
Barrett's Esophagus	_____	_____
Colon polyps	_____	_____
Colon cancer	_____	_____
Crohn's disease or ulcerative colitis	_____	_____
Esophageal or stomach cancer	_____	_____

In the last 2 months have you had any of the following: Circle all that apply

Fatigue	Fever	Sweats	Weight loss
Headaches	Change in vision	Hearing problems	Sore throat/Hoarseness
Cough	Short of breath	Chest pain	palpitations
Back pain	Joint pain	Swollen legs	Weakness arm/leg
Blood in urine	Pain when urinating	Bleed easily	Bruise easily
Skin rash	Memory changes		

Drug Allergies:_____ ☐ No known allergies **Meds:** see chart

_____ _____
Date signed by pt Signature of patient