DIGESTIVE DISEASE SPECIALISTS, P.C.

PATIENT HEALTH HISTORY FORM

Patient name: _____DOB_____ Age_____

Referring Physician:_____Primary Care Physician:_____

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?

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 previous endoscopic evaluations?

Date of most recent upper endoscopy (EGD)_____ and Colonoscopy _____

Y N Have you had previous CT/MRI/Ultrasound of the GI tract? If so, where and when?_____

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 so, I smoke _____packs per day and have been smoking for _____yrs.

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

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
Cancer, if so, what type**:**	Diabetes Mellitus		
Other:			

Family history of GI problems: ⌗ Unknown as I am adopted ⌗ None known
Relation to you Age at diagnosis

Barrett's Esophagus _____

Colon polyps or 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 Date signed by MD Physician signature