HEALTH HISTORY QUESTIONNAIRE

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Patient's Name:	**DOB:**	**GENDER:**

MEDICATIONS: PLEASE LIST ALL CURRENT MEDICATIONS WITH DOSAGE AND FREQUENCY
EXAMPLE: METFORMIN 10MG TWICE A DAY

NAME OF DRUG	**DOSE**	**FREQUENCY**
EXAMPLE: METFORMIN	***10MG***	***TWICE A DAY***

Allergies and Reactions

Allergy to Latex? YES_____ NO_____

Medication:	**Reaction:**

Patient's Name:	DOB:

PAST MEDICAL HISTORY: Please indicate if you have been diagnosed with any of these conditions:

	Y	N		Y	N		Y	N
AIDS/HIV			Emphysema/Bronchitis			Migraines/Headaches		
Anal Abscess			Epilepsy/Seizures			Osteoporosis		
Anal Fissure			Gallstones			Pacemaker		
Anal Fistula			Glaucoma			Pneumonia		
Angina/Chest Pain			GI Conditions			Prostate/Enlarged		
Anxiety/Rheumatism			Hearth Attack			Prostate Cancer		
Asthma			Heart Disease			Psoriasis		
Blood Cloths			Heart Valve Disease			Sickle Cell Disease		
Blood Disorder/Anemia			High Blood Pressure			Sleep Apnea		
Colon or Rectal Cancer			Heart Murmur			Stroke		
Colon or Rectal Polyps			Hemorrhoids			Thyroid Condition		
Crohn's Disease			Hepatitis B/Hepatitis C			Tuberculosis		
Defibrillator			Irregular Heart Beat			Ulcerative Colitis		
Dementia/Alzheimer's			Irritable Bowel Syndrome/IBS			Ulcers		
Depression			Irritable Bowel Disease/IBD			Urine Infections		
Diabetes			Kidney Disease/Failure			Vision/Hearing Issues		
Diverticulitis/Diverticulosis			Lung Disease					
Eczema			Mental Illness					

	Age	Type	Date Diagnosed
Personal History of Cancer			

	Yes	No	Date treated
Have you ever been diagnosed with MRSA?			

Please Indicate other known medical problems:

Patient's Name:	DOB:

Surgical and Colonoscopy History

	Yes	No	Date/Facility
Have you ever had a Colonoscopy?			
Have you ever had a Flexible Sigmoidoscopy?			

Procedure	Date	Hospital/Physician

Surgical Complications:

Have you ever had any major problems/reactions with Anesthesia? Yes_____ No _____

If you answered Yes, please explain: _____

Have you ever had any excessive bleeding problems with surgery? Yes _____ No _____

Hospitalizations

Reason	Date	Hospital/Physician

Patient's Name:	DOB:

Family History

Has anyone in your family been diagnosed with the following?

Diagnosis	Relationship to you	Age of Diagnosis
Colon or Rectal Cancer		
Ulcerative Colitis		
Crohn's Disease		
Polyps		
Familial Adenomatous Polposis (FAP)		
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Thyroid Cancer		
Stomach Cancer		
Bladder/Ureter Cancer		
Prostate Cancer		
Pancreatic Cancer		
Renal/Pelvis Cancer		
Biliary Tract Cancer		
Brain Cancer		
Other Cancer:_____		
Other Diagnosis:_____		
Other History:_____		

Social History

Are you:	married	divorced	single	widowed	
Who do you live with?					
Do you have a living will?	No	Yes			
Do you smoke?	No	Yes	How many pack/day?	What age began?	
Have you ever smoked?	No	Yes	Date stopped:		
Do you vape?	No	Yes			
Do you drink?	No	Yes	Frequency?	Amount?	Type?
Do you use recreational drugs?	No	Yes	Type of drug:		

Patient's Name:	DOB:

REVIEW OF SYSTEMS: Please indicate all that apply to you

Constitutional symptoms	Y	N	Ear, Nose, Throat	Y	N	Neurological	Y	N
Weight gain/loss			Hearing Loss			Headaches		
Fevers			Nose Bleeds			Dizziness/Vertigo		
Night Sweats			Sore throat			Seizures		
Fatigue			Pain Swallowing			Weakness		
Loss of appetite						Numbness		
Cardiac	**Y**	**N**	**Genitourinary**	**Y**	**N**	**Psychiatric**	**Y**	**N**
Chest pain/heaviness			Frequent voiding			Depression		
Shortness of breath with activity			Pain with voiding			Anxiety		
Shortness of breath at rest			Blood in urine			Mood Changes		
Irregular heart beat/palpitations			Sexual dysfunction			Memory Problems		
Lightheadedness/fainting			Groin pain					
Gastrointestinal	**Y**	**N**	**Hematologic**	**Y**	**N**	**Breast Health**	**Y**	**N**
Abdominal pain			Abnormal bleeding/bruising			Breast cysts/lumps		
Nausea/vomiting			Clotting problems			Breast skin changes		
Heartburn			Transfusion problems			Nipple discharge		
Constipation or diarrhea			Anemia			Breast pain		
Blood with stools			Blood clots			Recent mammogram - Date		
Endocrine	**Y**	**N**	**Skin & Integumentary**	**Y**	**N**	**Ob/GYN**	**Y**	**N**
Heat/cold intolerance			Rashes			Number of Pregnancies:		
Excessive thirst			Sores			Number of Life Births:		
Excessive voiding			Blisters			C-section?		
Excessive appetite			Growths			Menstrual period regular		
Excessive hair growth			Hair loss			Menstrual period irregular		
						Postmenopausal		
Musculoskeletal	**Y**	**N**	**Respiratory**	**Y**	**N**	Recent PAP smear		
Joint pain/swelling			Cough			If yes, approximate date:		
Stiffness			If Yes, check all that applies:					
Weakness of limbs			___ Dry ___ Bloody			**OTHER:**	**Y**	**N**
Back pain/sciatica			___ Green ___ White			Have you ever had any bleeding problems?		
Gout			___ Voice Change ___ None					
						Have you ever had a blood transfusion?		
Eye, Vision	**Y**	**N**	Wheeze					
Double Vision			Shortness of breath			Have you had any anesthesia problems?		
Visual Changes			Blood in sputum					
			Early waking/snoring			Do you have any metal implants?		

Thank you for providing us with this important information

Signature: _____ Date: _____

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