



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:	AGE:	SEX:
<p>Reason for today's visit:</p> <p>What is bothering you?</p> <p>For how long?</p> <p>How frequently does it happen?</p> <p>Is it getting better or worse?</p>			

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

NAME OF DRUG	DOSE	FREQUENCY
<i>EXAMPLE: METFORMIN</i>	<i>10MG</i>	<i>TWICE A DAY</i>

Allergies and Reactions

Allergy to Latex? YES _____ NO _____	
Medication:	Reaction:



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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					

Personal History of Cancer	Age	Type	Date Diagnosed
	Yes	No	Date treated
Have you ever been diagnosed with MRSA?			

WOMEN: Age at onset of menstruation: _____ Date of last menstruation: _____

Number of Pregnancies: ____ Number of Live Births: ____ Number of Vaginal Deliveries: ____ Number of C-sections: ____

Were any of your children very big, long, or difficult deliveries? Yes No Forceps? _____ Vacuum? _____

Did you have a very large tear with lots of stitches? Yes No

Have you had a D&C or hysterectomy? Yes No

MEN:

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No

Please Indicate other known medical problems:



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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



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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)		
Cancer type:		
Cancer type:		
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:	

Gastrointestinal History

Diarrhea	Y	N	Constipation	Y	N
Visible blood with bowel movement:	Y	N	Dark Maroon	Bright Red	(circle answer)
Pain with defecation:	Y	N	Sharp	Achy	Burning (circle answer)
Anal Itching	Y	N			
Do you have stool incontinence or accidents?	Y	N	How often:		
Do you have minor spotting or soiling?	Y	N	How often:		
How often do you move your bowels?	_____		Bowel Movements are: normal hard soft loose watery		
Do you take laxatives:	Y	N	Name: _____	Frequency: _____	
Do you take or use:	enema	suppository	How often: _____		



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REVIEW OF SYSTEMS: Please indicate all that apply to you									
Constitutional symptoms	Y	N	Ear, Nose, Throat	Y	N	Neurological	Y	N	
Weight gain			Hearing Loss			Headaches			
Weight loss			Nose Bleeds			Dizziness/Vertigo			
Fevers			Sore throat			Seizures			
Night Sweats			Pain Swallowing			Weakness			
Fatigue						Numbness			
Loss of appetite									
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			Clotting problems			Breast skin changes			
Vomiting			Transfusion problems			Nipple discharge			
Heartburn			Anemia			Breast pain			
			Blood clots			Recent mammogram - Date			
Endocrine	Y	N	Skin & Integumentary	Y	N	Ob/GYN	Y	N	
Heat/cold intolerance			Rashes			C-section?			
Excessive thirst			Sores			Menstrual period regular			
Excessive voiding			Blisters			Menstrual period irregular			
Excessive appetite			Growths			Postmenopausal			
Excessive hair growth			Hair loss			Recent PAP smear			
						If yes, approximate date:			
Musculoskeletal	Y	N	Respiratory	Y	N				
Joint pain/swelling			Cough						
Stiffness			If Yes, check all that applies: ___ Dry ___ Bloody ___ Green ___ White ___ Voice Change ___ None						
Weakness of limbs						OTHER:	Y	N	
Back pain/sciatica						Have you ever had any bleeding problems?			
Gout						Have you ever had a blood transfusion?			
Eye, Vision	Y	N	Wheeze			Have you had any anesthesia problems?			
Double Vision			Shortness of breath			Do you have any metal implants?			
Visual Changes			Blood in sputum						
			Early waking/snoring						

Thank you for providing us with this important information

Signature: _____

Date: _____



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