

# Comprehensive Gastroenterology

## Health History Questionnaire

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Reason For Visit: \_\_\_\_\_ PCP/Referring M.D.: \_\_\_\_\_

*Are you being seen for any of the following? Please check ALL that apply.*

Abdominal Pain	Cirrhosis	Nausea
Abdominal Swelling	Crohn's Disease	Obesity Consult
Abnormal CT/MRI	Diarrhea	Rectal Bleeding / Blood in Stool
Abnormal Liver Test	Follow Up Test Results	Rectal Pain
Anemia	Gas and Bloating	Trouble Swallowing
Black Tarry Stool	Heartburn	Ulcer Colitis
Change in Appetite	Hepatitis	Vomiting
Change in Bowel Habits	Indigestion	Vomiting Blood
Constipation	Jaundice	Weight loss: Amount?

*Have you ever been diagnosed with any of the following? Please check ALL that apply.*

Anxiety / Depression	Diabetes	Memory Loss
Arthritis	Diverticulosis / Diverticulitis	Nervousness / Panic Attacks
Asthma	Emphysema / COPD	Pelvic Infections
Barret's Esophagus	Excessive Scar Tissue / Adhesions	Pneumonia
Blood Clot in leg	Gallstones	Poor Circulation
Blood Clot in Lung	Gastritis	Prostate Problems
Cancer: Kind?	Heart Attack	Seizures
Colitis	Hepatitis	Sinus Trouble
Colon Cancer	High Blood Pressure	Stroke
Colon Polyps	High Cholesterol	Thyroid Problems
Congestive Heart Failure	Irregular Heart Beat	Ulcers
Crohn's Disease	Kidney Stones	Valvular Heart Disease

*Have you ever had any of the following operations? Please check ALL that apply.*

Artificial Blood Vessel Graft	Knee Surgery / Replacement	Removal of all / part colon
Eye Surgery	Placement of Artificial Joint	Removal of Spleen
Heart Bypass	Prostate Surgery	Replacement of Heart Valve
Heart Catheterization	Removal of Gallbladder	"Roto-Rooter" of Blood Vessels
Hemorrhoid Surgery	Removal of Kidney	Tonsillectomy
Hysterectomy	Removal of part / all of stomach	Tubaligation

*Social History. Please check ALL that apply.*

Never a smoker	No Caffeine	Do not drink alcohol
Smoke daily: How much?	Tea	Drink alcohol daily
Former smoker: Quit when?	Carbonated Drinks	Drink alcohol on a weekly basis
Chew/Dip/Snuff	Energy Drinks	Drink alcohol socially
E-Cigarette / Vape	Coffee	Recovering alcoholic: How long?

*Family history of medical problems. Please indicate family member next to problem.*

Celiac Disease	Esophageal Cancer	Liver Cancer
Colitis	Gastric Cancer	Lung Disease
Colon Cancer	Heart Disease	Pancreatic Cancer
Crohn's Disease	High Cholesterol	Stomach Cancer
Diabetes	Hypertension	Ulcerative Colitis

*Gastro Medical History. Please list dates of last procedures.*

Colonoscopy	EGD	Flex Sig
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Are you currently on any blood thinners?

Do you have any allergies to medications?

**Please list your pharmacy name, phone number and address:**

Please list any medications that you are currently taking: