HEALTH HISTORY (1 of 2)

For office use only

Patient Name: _____

Past Medical History (Please indicate if you have been diagnosed with any of the following)

□ Type 1 Diabetes
□ Type 2 Diabetes - Insulin Y or N
□ High blood pressure
□ Thyroid disease
□ HIV Positive
□ MRSA
□ High cholesterol
□ Anemia
□ Anxiety/Depression/Mental Illness (circle)
□ Cancer Type: _____
□ Heart attack
□ Coronary Artery disease
□ Peripheral Vascular Disease
□ Congestive heart failure
□ Valvular disease
□ Atrial fibrillation
□ Stroke
□ Seizures
□ Arthritis □ Rheumatoid Arthritis
□ Asthma
□ Emphysema
□ Sleep apnea - Do you use oxygen? Y or N
□ Prostate problems
□ Renal failure
□ Emphysema/COPD
□ Other (list)

Gastrointestinal specific:
□ Crohn's Disease
□ Ulcerative Colitis
□ Colon polyps
□ Acid reflux or GERD- (Gastroesophageal Reflux Disease)
□ Stomach ulcers
□ Diverticulosis
□ Hepatitis/Liver disease
□ Irritable Bowel Syndrome
□ Barrett's Esophagus
□ Celiac

Surgeries (Please indicate if you had any of the following)

□ Appendix removed
□ Gallbladder removed
□ Uterus/Ovaries removed
□ Hemorrhoids removed
□ Heart bypass/angioplasty
□ Defibrillator/pacemaker
□ Artificial heart valves
□ Knee/Hip replacements
□ Tonsils removed
□ Hernia surgery
□ Cataracts removed
□ Other _____

Procedures/Laboratory/Radiology Histoy for Gastrointestinal (Please indicate if you had any of the following)

Stool tested for blood	□ Y □ N	Date:	Location:
Colonoscopy or Flexible Sigmoidoscopy	□ Y □ N	Date:	Location:
MRI/CT scan of abdomen	□ Y □ N	Date:	Location:
Barium Enema or Barium upper gastrointestinal series	□ Y □ N	Date:	Location:
Liver Biopsy	□ Y □ N	Date:	Location:
EGD or Upper Endoscopy	□ Y □ N	Date:	Location:

Personal History

How may years of school have you completed? _____

What is your current employment status? □ Stay at Home Parent □ Unemployed □ Student □ Retired
□ Employed Part-time □ Employed Full-time Position: _____
Previous Occupation: _____

Do you have a disability? □ Yes □ No Cause:

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Do you have children? □ Yes □ No Number of sons? _____ Number of daughters? _____

How would you rate your diet? □ Poor □ Average □ Good □ Excellent □ Vegetarian

How would you rate your daily physical activity? □ sedentary □ inconsistent □ regular exercise
□ occasional exercise type of exercise? _____ □ active lifestyle (no organized exercise)

What is your experience with smoking? □ none □ current smoker-start date____ □ socially smoke cigarettes
□ secondary smoking exposure □ no secondary smoking exposure □ former smoker-quit date____

If you smoke, how many packs per day? _____ per week? _____

Tobacco exposure is: □ smokers in the home □ no smokers in the home

Do you use any other form of tobacco? □ Yes □ No Type? _____ how often? _____

What is your experience with alcohol? □ none □ rare alcohol □ occasional alcohol □ currently drink alcohol
□ socially drink alcohol □ occasional glass of wine □ former drinker-quit date____ □ alcohol dependency
□ recovering alcoholic-quite date____ □ binge drink how much? _____ how often? _____

HEALTH HISTORY (2 of 2)

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Patient Name: _____

Personal History (cont)

Have you been __sexually __emotionally __physically abused? □ No

Describe your sexual activity? □ not sexually active □ Monogamous □ practice safe sex

Do you use illicit or street drugs? □ Yes □ No If Yes, what do you use? _____ how often? _____

Have you used illicit or street drugs? □ Yes □ No What did you use? _____ how often? _____

Family History (Please mark an "X" to indicate if any blood relative had the following)

Condition	Mother	Father	Sibling	Other Family Member	Comment
Arthritis					
Asthma					
Coronary Artery Disease					
High Cholesterol					
Depression					
Epilepsy					
Alcoholism					
Diabetes (Type 1 or 2)					
Genetic Disorder					
Heart Disease					
High Blood Pressure					
Lung Disease					
Mental Illness					
Migraines					
Kidney Disease					
Stroke					
Ulcerative Colitis					
Liver Disease					
Crohn's Disease					
Colon Polyps					
Irritable Bowe Syndrome					
Celiac Disease					
Hepatitis B					
Hepatitis C					
Acid Reflux					
Ulcers					

Cancer – Please list family member and age at cancer diagnosis (if applicable). Include Parents, Siblings, Children, Grandparents, Uncles, Aunts and Cousins. Indicate "P" for paternal or "M" for maternal. Example: Grandmother-P

Breast:	age:	Colon/Rectal:	age:	Other: (list type)	
Ovarian:	age:	Pancreatic:	age:		age:
Uterine:	age:	Melanoma:	age:		age:

Medical Providers (Please list below the physicians currently treating your conditions)

Primary Care or Family Physician _____

Cardiologist _____

Endocrinologist _____

Transplant physician _____

Oncologist _____

Nephrologist _____

Other (Please specify condition)