HEALTH HISTORY

Name _____ Date of Birth _____ Date _____

Prior Endoscopy (EGD): Date: _____ Findings: _____
Prior Colonoscopy: Date: _____ Findings: _____

Family History: Indicate any known illnesses of **family members** and their **relationship** to patient.

Colon Cancer (relation) _____
Colon Polyps (relation) _____
Stomach Cancer (relation) _____
Crohn's Disease (relation) _____
Ulcerative Colitis (relation) _____
Gallstone (relation) _____
Liver disease/Cirrhosis (relation) _____
Other cancer (relation) _____
Pancreatitis (relation) _____
Esophagus cancer (relation) _____

List illnesses or operations and approximate year:

Hospitalizations/Surgeries **Year**

_____
_____
_____
_____
_____
_____
_____

Social History

Are you a current or former smoker? YES NO How many packs per day? _____

How many years have you smoked? _____ When did you quit? _____

Do you drink alcohol? YES NO What type do you drink? _____ How often? _____

How many years have you drank? _____ When did you quit? _____

Do you use recreational drugs? YES NO What type do you use? _____

How many years have you used it? _____ How often? _____ When did you quit? _____

Recent foreign travel? YES NO When? _____ Where? _____

HEALTH HISTORY

Name: _____ Date of Birth: _____ Date:_____

Personal Medical History

Constitutional ☐ Weight loss ☐ Loss of appetite ☐ Weakness ☐ Fever ☐ Night sweats ☐ Fatigue ☐ Anemia ☐ Normal	**ENT** ☐ Cough ☐ Hearing loss ☐ Coughing blood ☐ Change in voice ☐ Nose bleed ☐ Sore throat ☐ Normal
Ophthalmology ☐ Diminished vision ☐ Loss of vision ☐ Blurring vision ☐ Normal	**Endocrinology** ☐ Fatigue ☐ Diabetes ☐ Excessive sweating ☐ Cold intolerance ☐ Excessive thirst ☐ Heat intolerance ☐ Thyroid disorder ☐ Normal
Allergy ☐ Scratchy throat ☐ Sinus congestion ☐ Normal	**Cardiology** ☐ Shortness of breath ☐ Chest pain ☐ Palpitations ☐ Heart murmur ☐ Blood clots ☐ Heart attacks ☐ Irregular heartbeat ☐ Normal ☐ High blood pressure ☐ Cardiac Stent placed in last 12 months
Respiratory ☐ Shortness of Breath ☐ Chest congestion ☐ Tuberculosis ☐ Tuberculosis vaccination Date: _____ ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Oxygen ☐ Sleep apnea ☐ Uses CPAP ☐ Does not use CPAP ☐ Normal	**Gastroenterology** ☐ Nausea ☐ Heartburn ☐ Stool incontinence ☐ Weight loss ☐ Vomiting ☐ Bloating/belching ☐ Difficulty swallowing ☐ Abdominal pain ☐ Diarrhea ☐ Constipation ☐ Blood in stool ☐ Change in bowel habits ☐ C. Difficile ☐ Hepatitis Type of hepatitis? _____ ☐ Vaccination Hepatitis A Date: _____ ☐ Vaccination Hepatitis B Date: _____
Urology ☐ Difficulty urinating ☐ Urinary incontinence ☐ Frequent urination ☐ Normal	**Dermatology** ☐ Rash ☐ Normal ☐ MRSA
Neurology ☐ Headache ☐ Tingling numbness ☐ Seizures ☐ Memory loss ☐ Normal	**Hematology/Lymph** ☐ Swollen glands ☐ Normal ☐ Easy bruising
Musculoskeletal ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Recent falls ☐ Lock Jaw ☐ Normal	**Psychology** ☐ Depression ☐ Anxiety Disorder ☐ Eating disorder ☐ Normal

List any other symptoms: _____

Weight _____ Height _____