Digestive Disease Consultants, P.C.

Health History

Name:_____

Birthdate:_____ Today's Date:_____

Female ____ Male____

Married___ Single___ Widowed___ Divorced__

List Allergies: _____

Medical Surgical: History Check all that applies: **List Other Medical hx/ Surgeries:**

	Hypertension		Colon Cancer	
	Stroke		Crohns/Ulcerative colitis	
	Heart Stent __<1yr ___>1yr		Appendectomy	
	Congestive Heart Failure		Gall Bladder Surgery	
	Atrial Fibrillation		Diverticulosis	
	Heart Defibrillator/ICD		Pancreatitis	
	Heart Valve Surgery		Hepatitis	
	Heart Bypass Surgery		Colon Polyps	
	Asthma		Gastric Bypass	
	Emphysema/COPD		Joint Replacement__<1yr__>1yr	
	Diabetes___type1_____type2		Liver Disease	
	Kidney Failure Dialysis		Cirrhosis	
	Pacemaker		C Section	
	Hemochromatosis		Endometriosis	
	Thyroid disease		Hysterectomy	

In order to comply with the Affordable Care Act, we are asking our patients to answer the following:

What is your race? _____Ethnicity? _____Decline to answer_____

Do you speak English? _____yes _____no **If no, what language do you speak**? _____

Please check all that applies:

Family History: (mother, father, brother, sister) **Social History**;

	Cancer: Who? _____Age?_____ Type**?**		Ever Smoke? How much? _____How long? _____ Quit? _____When? _____
	Diabetes**:** Who**? _____**		Alcohol use? How much? _____ Quit? _____ When? _____
	Heart Disease: Who? _____		Marijuana or Illicit drug? ____ How much?
	Stroke: Who? _____		Caffeinated Beverages? What kind?_____ How Much?_____
	Liver Disease**:** Who**? _____**		
	Crohn's: Who? _____		
	Ulcerative Colitis: Who? _____		
	Colon Polyp: Who? _____		

Nutrition: Have you had any unplanned weight change in the past 6 months? __Yes __No. If yes how many pounds? Gain_____ Lost_____

PLEASE READ AND SIGN OTHER SIDE----------->

Please check yes to all that apply:

Current Symptoms

Constitutional

Fever __Yes
Weight Loss __Yes

HEENT

Double Vision __Yes
Hearing loss __Yes

Respiratory

Shortness of Breath __Yes
Frequent cough __Yes
Spitting up blood __Yes
Wheezing __Yes

Cardiovascular

Chest pain or pressure __Yes
Swelling ankles __Yes
Palpitations __Yes

Gastrointestinal

Abdominal Pain __Yes
Change in bowel habits __Yes
Constipation __Yes
Diarrhea __Yes
Swallowing Difficulties __Yes
Heartburn __Yes
Vomit blood __Yes
Blood in stool __Yes
Black stool __Yes
Nausea __Yes
Reflux __Yes
Vomiting __Yes
Stool urgency __Yes

Neurological

Headaches __Yes
Dizziness __Yes

Genitourinary

Difficult urination __Yes
Blood in urine __Yes

Metabolic/Endocrine

Heat or cold intolerance __Yes
Excessive thirst __Yes

Musculoskeletal

Muscle pain ___Yes
Joint pain ___Yes
Anti-inflammatory med ___ Yes

Hematologic

Easy bleeding __Yes
Easy bruising __Yes
Blood thinning med __ Yes

Immunologic

Food allergies ___Yes
Seasonal Allergies ___Yes

Permission granted for Doctor or medical staff to access my complete medication history. _____yes
_____no

Patient Signature:_____ Date:_____

Reviewed by: _____ Date:_____

Patient Name: _____ Date: _____
Date of Birth_____

Medication Name	Strength	How taken