Patient #_____

PATIENT HEALTH HISTORY

Name: _____ Birthdate: _____ Today's Date: _____

Please help us by taking the time to complete the following information on this form as accurately as possible. The information obtained on this form will remain confidential and will become part of your patient record. Thank you for your cooperation.

CHIEF COMPLAINT: (Please check the symptoms that you currently have)

__ Weight Loss/Poor Appetite
__ Fever/Chills
__ Abdominal Pain
__ Constipation
__ Diarrhea
__ Rectal Bleeding/Blood in Stool
__ Change in Bowel Habits
__ Nausea/Vomiting
__ Chest Pain
__ Cough
__ Heart
__ Hoarseness
__ Swallowing Difficulties
__ Pain with Swallowing
__ Anemia
__ Others not listed _____

_____

Personal Medical History

Surgery:	**Year:**	**Details/Complications:**
__ Appendectomy	_____	_____
__ Gallbladder	_____	_____
__ Hernia Repair	_____	_____
__ Hysterectomy	_____	_____
__ Intestinal/Abdominal	_____	_____
__ Stomach/Duodenal Ulcer	_____	_____
__ Surgery Not Listed Above	_____	_____
	_____	_____
	_____	_____

Hospitalizations other than surgery:	**Date/Hospital**
_____	_____
_____	_____
_____	_____
_____	_____

Previous Endoscopies (Colonoscopy, EGD, ERCP)	**Date**
_____	_____
_____	_____
_____	_____

Current Medical Problems:

__ Arthritis
__ Cancer, Type: _____
__ Defibrillator/Pacemaker
__ Heart Problems: _____
__ High Blood Pressure
__ Stent Placement: _____
__ Thyroid Problems
__ Cervical Pap Date: _____
__ Prostate Exam Date:_____
__ Asthma
__ Crohn's/Colitis
__ Epilepsy/Seizure
__ Hepatitis
__ Kidney Disease
__ Sleep Apnea
__ History of H. pylori
__ Last Mammogram Date:_____
__ Anxiety/Depression
__ Diabetes
__ Gallstones
__ Lung Disease
__ Osteoporosis
__ Stroke

Diabetics Only: Last A1C _____ Last Eye Exam _____

__ Other: _____

Patient #_____

Name: _____ Birthdate: _____ Today's Date: _____

Medications: (Include prescriptions, over-the-counter, and herbals products)

Name	**Dose/Frequency**	**Preferred Pharmacy:**
_____	_____	_____
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Allergies to Medications: (Include latex/tape, iodine, and/or severe adverse)

Medication	Reaction
_____	_____
_____	_____
_____	_____

Are you allergic to Latex?
__ Yes __ No

Family History: (Please include **age** of diagnosis for family member)

	Father	Mother	Brother/Sister	Other
Colon Cancer	_____	_____	_____	_____
Colon or Rectal Polyps	_____	_____	_____	_____
Stomach/Small Bowel Cancer	_____	_____	_____	_____
Pancreatic Cancer	_____	_____	_____	_____
Uterine/Ovarian Cancer	_____	_____	_____	_____
Renal/Ureteral Cancer	_____	_____	_____	_____
Breast Cancer	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____
Gallbladder Disease	_____	_____	_____	_____
Colitis/Crohn's Disease	_____	_____	_____	_____
Other	_____	_____	_____	_____

Social History: (Past or Current)

Alcohol ___ No ___ Quit/When _____ ____ Yes ____ Drinks per Day ____ # Years

Tobacco _____ Cigarette _____ E-Cigarette ____ Pipe ____ Cigar ____ Chewing

___ No ___ Quit/When _____ ____ Yes ___ Packs per Day ____ # Years

Recreational Drug Use ___ No ___ Quit/When _____ ____ Yes

Drugs Used _____ Used Needles _____ Yes _____ No

Coffee/Caffeine Use ___ No ___ Quit/When _____ ____ Yes ____ Amount per Day ____ # Years

Blood Transfusions ___ No ___ Yes When? _____

Tattoos/Piercings ___ No ___ Yes

Do you take **antibiotics** prior to dental work on a regular basis? ___ No ___ Yes Why?_____

Immunizations:

Flu Vaccine ___ No ___ Yes Date: _____

Pneumonia Vaccine ___ No ___ Yes Date: _____

COVID-19 Vaccine ___ No ___ Yes Date(s): _____ _____

Thank you for your time and cooperation.