



HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <small>(Last, First, M.I.):</small>	Date of Birth:
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Briefly describe your symptoms

List any medical problems that other doctors have diagnosed

List any past surgeries, colonoscopies or upper endoscopies		
Year	Reason	Hospital / Surgeon

Describe any other hospitalizations		
Year	Reason	Hospital / Physician

Please turn to next page

List your prescribed drugs and over-the-counter drugs or give your list to the nurse

Name the drug or food	Strength	Frequency Taken

Do you have any allergies to medications? Yes No If yes, please include any over the counter or food allergies.

Name the Drug	Reaction You Had

Please answer the following questions and check all that apply.

Tobacco	Current every day smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Current some day smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Former smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Never smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you use smokeless tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol	Do you drink alcohol, beer or wine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drugs	Do you use street or recreational drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please list any health problems in your family below.

	AGE	SIGNIFICANT HEALTH PROBLEMS		SEX	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps	Children	<input type="checkbox"/> M		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps
				<input type="checkbox"/> F		
Mother		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps		<input type="checkbox"/> M		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps
				<input type="checkbox"/> F		
Grandmother <i>Maternal</i>		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps		<input type="checkbox"/> M		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps
Grandfather <i>Maternal</i>		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps		<input type="checkbox"/> F		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps
Grandmother <i>Paternal</i>		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps	Your siblings	<input type="checkbox"/> M		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps
Grandfather <i>Paternal</i>		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps		<input type="checkbox"/> F		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps
				<input type="checkbox"/> M		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps
			<input type="checkbox"/> F		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps	

Please turn to next page

Do you have any of the following symptoms? Check the box "yes" or "no" to the right.		
General	Fevers or chills	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Poor appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes	Visual problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ears, nose & throat	Mouth sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart and blood vessels	Recurrent chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Discomfort breathing by lying flat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lungs	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal tract or bowel	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Heartburn or indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Bleeding from rectum	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Nausea or vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Bloating or cramping	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Rectal or anal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urinary system	Anal leakage or incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Stool or gas in urine stream	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscles and bones	Leakage of urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Limitation of motion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin and breast	Joint or bone pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brain and nerves	Breast mass	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Recurrent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatry	Fainting or syncope	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine and glands	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Temperature intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood & immune system	Thyroid or other gland problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Easy bruising or bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
	HIV positive or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please fill this form out at home and bring it with you.

You can also fax this form to the office 2 days prior to your appointment date.

Fax number (210) 490 - 0505