



## HEALTH HISTORY QUESTIONNAIRE

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

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

<b>List any medical problems that other doctors have diagnosed</b>

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

<b>Describe any other hospitalizations</b>		
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.**

<b>Tobacco</b>	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
<b>Alcohol</b>	Do you drink alcohol, beer or wine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Drugs</b>	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
<b>Father</b>		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps	<b>Children</b>	<input type="checkbox"/> M		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps
				<input type="checkbox"/> F		
<b>Mother</b>		<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		
<b>Grandmother</b> <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
<b>Grandfather</b> <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
<b>Grandmother</b> <i>Paternal</i>		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps	<b>Your siblings</b>	<input type="checkbox"/> M		<input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Colon cancer or colon polyps
<b>Grandfather</b> <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*

<b>Do you have any of the following symptoms?</b> 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
Anal leakage or incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Urinary system	Stool or gas in urine stream	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Leakage of urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscles and bones	Limitation of motion	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Joint or bone pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin and breast	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Breast mass	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brain and nerves	Recurrent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Fainting or syncope	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatry	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine and glands	Temperature intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Thyroid or other gland problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood & immune system	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**