Advanced Endoscopy Center
Health History Questionnaire

Name (First, MI, Last)	☐ Male ☐ Female	Date of Birth:
Primary Care Provider:	Referring Provider:	
Preferred Pharmacy and Location:	Pharmacy Phone Number:	

Reason for Visit & Problems:

Medications
(Including over the counter medications) Please list all medications and/or bring a list with you.

Do you use any of the following?

YES	Medication Name	Strength of each dose?	How many times per day?
☐	**NO MEDICATIONS**		
☐	Tylenol (Acetaminophen)		
☐	Aspirin, Anacin or Bufferin		
☐	Ibuprofen (Advil,Motrin) or Naproxen (Aleve)		
☐	Laxative or Stool Softeners		
☐	Iron		
☐	Blood Thinners (Coumadin/Warfarin/Plavix)		
☐	Vitamins / Herbal Medications	(Please list below)	
☐	Other Non-Prescription Drugs	(Please list below)	

Medication Name	Strength of each dose?	How many times per day?

Allergies: Do you have any allergies? Please list medication, food allergies and reaction.

☐ NO KNOWN ALLERGIES

Are you allergic to Latex? ☐ YES Are you allergic to Eggs? ☐ YES Are you allergic to Peanuts? ☐ YES

Medication or Food	Reaction

☐ No Diagnostic History	Diagnostic Procedure History		
☐ Abdominal/Pelvic Cat Scan	Month/Year:	☐ MRI - Abdominal	Month/Year:
☐ Abdominal/Pelvic Ultrasound	Month/Year:	☐ MRCP - Abdominal	Month/Year:
☐ Barium Enema	Month/Year:	☐ Sigmoidoscopy	Month/Year:
☐ Colonoscopy	Month/Year:	☐ Upper Endoscopy (EGD)	Month/Year:
☐ ERCP (endoscopic evaluation of the bile ducts)	Month/Year:	☐ Virtual Colonoscopy/CT	Month/Year:

☐ No Family History	Family History (Blood Relative)		
☐ Family History Unknown			
Colon Cancer	☐ Yes	☐ No	Relation:
Colon Polyps	☐ Yes	☐ No	Relation:
Crohn's Disease Ulcerative Colitis	☐ Yes	☐ No	Relation:
Liver Disease	☐ Yes	☐ No	Relation:
Gallbladder Disease	☐ Yes	☐ No	Relation:
Celiac Disease (gluten intolerance)	☐ Yes	☐ No	Relation:
Heart Disease	☐ Yes	☐ No	

Problem List / Medical History: Please check all that pertain to yourself			
☐ Alcoholism	☐ Diabetes	☐ HIV/AIDS	☐ Pancreatitis
☐ Anemia	☐ Diverticulosis	☐ High Cholesterol/Triglycerides	☐ Reflux
☐ Arthritis	☐ Gallstones	☐ Home Oxygen	☐ Renal Failure/Insufficiency
☐ Asthma	☐ Gastric or duodenal ulcer	☐ Hypertension	☐ Seizures
☐ Barrett's esophagus	☐ H.Pylori infection	☐ Liver disease or hepatitis	☐ Sleep apnea
☐ Cancer Type:	☐ Heart attack	☐ Lung disease/breathing difficulties	☐ Stroke or CVA
☐ Colon or rectal polyps	☐ Heart failure	☐ Osteoporosis	☐ Thyroid disease
☐ Depression	☐ Heart valve replacement	☐ Pacemaker/Defibrillator	☐ Ulcerative colitis or Crohn's

Social History

Occupation:

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Alcohol	☐ None ☐ Recovering Alcoholic				
	☐ Yes Drinks per week:_____	☐ Beer	☐ Wine	☐ Liquor	How often: ☐ Occasional ☐ Moderate ☐ Heavy ☐ Social
Tobacco	Do you use Tobacco?	☐ Yes	☐ No	☐ Quit Year___	
	If yes, please select type of Tobacco use.	☐ Cigarettes ___ # per day	☐ Chew ___ # per day	☐ Pipe ___ # per day	☐ Cigars ___ # per day
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No If yes, please list type of drug _____ How often? _____ Have you ever given yourself non-prescribed drugs with a needle? ☐ Yes ☐ No				

Surgical History			
☐ NO SURGICAL HISTORY		☐ Hernia Repair	Month/Year:
☐ Abdominal	Month/Year:	☐ Hysterectomy	Month/Year:
☐ Appendectomy	Month/Year:	☐ Ileostomy	Month/Year:
☐ Colectomy	Month/Year:	☐ Laparoscopy	Month/Year:
☐ Colon Resection	Month/Year:	☐ Liver	Month/Year:
☐ Gallbladder	Month/Year:	☐ Lung	Month/Year:
☐ Gastric Band	Month/Year:	☐ Pancreatic	Month/Year:
☐ Gastric Bypass	Month/Year:	☐ Reflux	Month/Year:
☐ Heart	Month/Year:	☐ Ulcer	Month/Year:

Changes in health in the past year (Please check only those items which apply)

GENERAL	CARDIOVASCULAR	☐ Decreased Appetite	HEME/LYMPH
☐ Weight Loss ____lbs	☐ Chest Pain	☐ Diarrhea	☐ Anemia
☐ Weight Gain ____lbs	☐ Irregular Heartbeat	☐ Difficulty in Swallowing	☐ Easy/Increased Bruising
☐ Fevers	☐ Abnormal Swelling legs/feet	☐ Gas	☐ Enlarged/Swollen Glands
☐ Chronic Fatigue	RESPIRATORY	☐ Heartburn	MUSCULOSKELETAL
SKIN	☐ Trouble Breathing	☐ Leakage of Stool	☐ Muscle Weakness
☐ Skin Rashes	☐ Persistent Cough	☐ Milk/Dairy Intolerance	Pain ☐ Neck ☐ Back ☐ Joints
☐ Jaundice (yellow skin or eyes)	☐ Coughing up Blood	☐ Mucus in stool	Stiffness ☐ Neck ☐ Back ☐ Joints
EAR-NOSE-THROAT	☐ Coughing up Sputum	☐ Nausea	NEUROLOGICAL
☐ Loss of hearing	☐ Asthma	☐ Rectal Pain	☐ Dizziness
☐ Hoarseness	☐ Wheezing	☐ Vomiting	☐ Headaches
☐ Sore Throat	GASTROINTESTINAL	☐ Vomiting of Blood	☐ Migraines
EYES	☐ Abdominal Pain	ENDOCRINE	☐ Stroke
☐ Cataracts	☐ Black Stools	☐ Excessive Thirst	☐ Seizures
☐ Glaucoma	☐ Bloating	☐ Excessive Urination	PSYCHOLOGICAL
	☐ Blood in Stool	☐ Intolerance to Cold	☐ Anxiety
	☐ Constipation	☐ Intolerance to Heat	☐ Depression
	☐ Cramps		

Thank you for your time. This information will assist us to help you. Remember to bring this form to your appointment. Please feel free to call if you have questions.

Patient Signature: _____ Date: _____