The Endoscopy Center / Digestive Healthcare Consultants

Confidential Health Questionnaire

Date: ______________________________

Name: ____

Date of Birth: ___________________________ Age: __________

Family Doctor: ____

Chief reason for your visit with us today: ____

Office Use Only
DHC: ____________________
TEC: ____________________

(please check all the following boxes that apply to your health history)

HEALTH MAINTENANCE

1. Is your appetite normal? ☐ Yes ☐ No If no, is it ☐ Increased ☐ Decreased

2. In the last 6 months, have you: ☐ Gained weight? How much? __________________
   ☐ Lost weight? How much? __________________
   ☐ Stayed the same

3. Do you have problems eating? ☐ Yes ☐ No
   Difficulty swallowing? ☐ Yes ☐ No If yes, what? _______ solids?
   _______ liquids?
   Painful swallowing? ☐ Yes ☐ No
   Nausea? ☐ Yes ☐ No
   Decreased taste sensation? ☐ Yes ☐ No

4. Have you been a patient in the hospital during the last 2 years? ☐ Yes ☐ No

5. Have you been under the care of a doctor during the past 2 years? ☐ Yes ☐ No

6. Have you ever smoked? ☐ Yes ☐ No
   If yes, do you still smoke? How much? (pks/day) ____ How many years? _____
   If quit, what year did you quit? ____ How many years did you smoke? _____

7. Do you drink alcoholic beverages? ☐ Yes ☐ No
   If yes, Beer - how many? _________ per day / week / month **(please circle one)**
   Shots - how many? _________ per day / week / month **(please circle one)**
   Wine - how many? _________ per day / week / month **(please circle one)**

8. How many cups / glasses of coffee, tea, or cola do you drink per day? _________________________

MEDICAL HISTORY

LUNG PROBLEMS
- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Tuberculosis

  Have you ever been exposed to TB? ☐ No ☐ Yes
- ☐ None
- ☐ Other ______________________

HEART PROBLEMS
- ☐ Anemia
- ☐ Aneurysm
- ☐ Angina (chest pain)
- ☐ Bleeding easily
- ☐ Blood clots
- ☐ Blood vessel disease
- ☐ Congestive heart failure
- ☐ Heart attack: year _________
- ☐ Heart murmur
- ☐ Hemophilia
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Leukemia
- ☐ Mitral valve prolapse
- ☐ Rheumatic fever: year ______
- ☐ Sickle cell disease
- ☐ None
- ☐ Other ______________________

MUSCLE / BONE PROBLEMS
- ☐ Arthritis
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Prosthesis - ☐ Arm ☐ Leg
- ☐ Myasthenia Gravis
- ☐ Uses assisted devices
- ☐ Other ______________________

NERVOUS SYSTEM PROBLEMS
- ☐ Migraine headaches
- ☐ TIA ☐ Stroke
- ☐ Epilepsy / seizures

  Date of last one: __________
- ☐ Multiple Sclerosis
- ☐ None
- ☐ Other ______________________

VISION PROBLEMS
- ☐ Blind ☐ Right ☐ Left
- ☐ Glaucoma
- ☐ Cataracts ☐ Right ☐ Left
- ☐ Implants ☐ Right ☐ Left
- ☐ Glasses
- ☐ Contacts ☐ Right ☐ Left
- ☐ Other ______________________

HEARING PROBLEMS
- ☐ Hard of Hearing ☐ Right ☐ Left
- ☐ Deaf ☐ Right ☐ Left
- ☐ Hearing Aide
- ☐ Other ______________________

DENTURES ___________________

GLAND / LIVER PROBLEMS
- ☐ Diabetic (sugar)
- ☐ Low blood sugar
- ☐ Thyroid
- ☐ Cirrhosis
- ☐ Hepatitis (Yellow jaundice)
- ☐ None
- ☐ Other ______________________

STOMACH/BOWEL PROBLEMS
- ☐ Crohn's
- ☐ Ulcerative colitis
- ☐ Diverticulosis / Diverticulitis
- ☐ Colon polyps
- ☐ Irritable bowel
- ☐ Hemorrhoids
- ☐ Colostomy
- ☐ Incontinence
- ☐ Diarrhea
- ☐ Esophageal varices (varicose veins)
- ☐ Hiatal hernia
- ☐ Reflux
- ☐ Inflammation of:
  - ☐ Esophagus (Esophagitis)
  - ☐ Stomach (Gastritis)
- ☐ Trouble swallowing (Dysphagia)
- ☐ Esophageal narrowing (stricture)
- ☐ Barrett's esophagus
- ☐ Ulcers
- ☐ Other ______________________

URINARY PROBLEMS
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Urinary tract infections
- ☐ Kidney dialysis
- ☐ Fistula: ☐ R arm ☐ L arm
- ☐ Ostomy
- ☐ Leaking urine

  ☐ with exercise ☐ all the time
- ☐ Enlarged prostate
- ☐ None
- ☐ Other ______________________

REPRODUCTIVE PROBLEMS
- ☐ Endometriosis
- ☐ Menopause
- ☐ Painful menstruation
- ☐ Pelvic pain
- ☐ Abnormal bleeding
- ☐ Vaginal discharge / inflammation
- ☐ Sexual transmitted (venereal) disease: what kind?

  ____
- ☐ None
- ☐ Other ______________________

  Is there a chance you may be pregnant? ☐ No ☐ Yes

Date of last menstrual period:

____

OTHER
- ☐ Alcoholism
- ☐ Cancer: what kind?

  ____

  ____

  ____
- ☐ Drug addiction:

  ____
- ☐ History of confusion
- ☐ Skin disease
- ☐ Mental illness
- ☐ Abuse: ☐ Physical ☐ Mental
- ☐ None
- ☐ Other ______________________

  ____

  ____

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  ____

OPERATIONS

Have you ever had Surgery? _____ YES ______ NO

☐ Appendix ☐ Aneurysm ☐ Back ☐ Bladder ☐ Bowel (colon) ☐ Breast ☐ Carotid artery ☐ Esophagus ☐ Eye: _______ Cataracts _______ Implants ☐ Gallbladder ☐ Heart ______ Bypass ☐ ________ Angioplasty ☐ ________ Valve	☐ Hernia ☐ Hiatal Hernia ☐ Hip ☐ Knee ☐ Kidney ☐ Lung ☐ Ovary ☐ Prostate ☐ Stomach ☐ Thyroid ☐ Tonsils ☐ Tubes (fallopian) tied ☐ Uterine ☐ Vasectomy	☐ Other: ______________________ ______________________ ______________________ ______________________ ______________________ ______________________

LEGAL DIRECTIVES

1. Do you have any of the following? (check all that apply)
   - ☐ Living Will
   - ☐ Durable Power of Attorney for healthcare decisions
   - ☐ Power of Attorney for financial matters

   You may wish to bring a copy of these documents to the office/Endoscopy Center so they have a record of your personal decisions.

2. Do you have a legal guardian? _____ Yes _____ No
   If yes, Name: ____ Phone No.: ______________________

FAMILY / SOCIAL HISTORY

☐ Has any family member (mother, father, brothers, sisters) living or deceased, had any of the following illnesses?

☐ Arthritis	☐ Diabetes
☐ Alcoholism	☐ Heart Disease
☐ Asthma	☐ High Blood Pressure / Stroke
☐ Cancer	☐ Hepatitis
☐ Colon / Gastric Cancers	☐ Kidney / Gout
☐ High Cholesterol	☐ Mental Illness
☐ Bleeding Disorders	☐ Tuberculosis
☐ Other	

☐ Are you married, single, divorced, separated? **(please circle one)**

☐ How many children do you have? __________________________________

☐ Are you working, unemployed, retired, on disability? **(please circle one)**

☐ What are your interests/hobbies? ____

____

____

____

PATIENT MEDICATION LIST

PLEASE LIST *ALL* MEDICATIONS YOUR TAKE

***Any prescription, *over the counter, *herbal medication & *vitamins.**

MEDICATION		DOSE		HOW OFTEN TAKEN

PLEASE LIST ALL ALLERGIES / ADVERSE REACTIONS / INTOLERANCE TO MEDICATIONS

MEDICATION		**ALLERGIC Reaction (example: rash)** **ADVERSE REACTION / INTOLERANCE** (example, nausea, vomiting)

The Endoscopy Center/Digestive Healthcare Use Only:

Medication list reviewed by: ______________________________________ Date ____________________