PROFESSIONAL GASTROENTEROLOGY ASSOCIATES, P.A.
HEALTH HISTORY QUESTIONNAIRE

IDENTIFICATION DATA

DATE_____

NAME_____ MALE_____FEMALE_____

ADDRESS_____ DATE OF BIRTH_____

_____ AGE_____

_____ OCCUPATION_____

TELEPHONE (H)_____(W)_____ MARITAL STATUS _____

SOCIAL SECURITY NUMBER_____ NAME OF SPOUSE_____

REFERRING PHYSICIAN _____ FAMILY PHYSICIAN_____

EMERGENCY CONTACT NAME AND PHONE NUMBER_____

CHIEF COMPLAINT

1. Please tell us why you are seeing the doctor today.

_____

_____

_____

2. Are you allergic to any medications that you are aware of?

YES_____**NO**_____ If yes, please list_____

_____

3. Are you allergic to any dyes, iodine, or shellfish?

YES_____**NO**_____ If yes, please list_____

_____

4. Please list all medications that you are currently taking.

_____

_____

_____

_____

PERSONAL HISTORY

Have you ever been told that you have any of the following conditions?
(Please circle **Yes** or **No**)

a. Gallbladder Disease	Yes	No
b. Problems with your Pancreas	Yes	No
c. Problems with your Liver	Yes	No
d. Stomach Problems	Yes	No
e. Intestinal Problems	Yes	No
f. Heart Disease	Yes	No
g. Lung Problems	Yes	No
h. High Blood Pressure	Yes	No
i. Diabetes	Yes	No
j. Stroke	Yes	No
k. Cancer	Yes	No
l. Thyroid Problems	Yes	No

If you answered yes to any of the above, please explain below (by letter(s)).

_____

_____

_____

Please note any known conditions other than those listed above.

_____

_____

_____

FAMILY HISTORY

Have any of your family members; parents, brothers, sisters, or children been told that they now have, or have had, any of the above conditions?

FATHER_____

MOTHER_____

BROTHER_____

SISTER_____

CHILDREN_____

REVIEW OF ILLNESSES

SYMPTOMS YOU HAVE NOTICED (PLEASE CIRCLE YES OR NO)			**IF YES, HOW LONG?**
1. Rectal Bleeding	Yes	No	_____
2. Change in Bowel Habits	Yes	No	_____
3. Black, Tarry Stools	Yes	No	_____
4. Constipation	Yes	No	_____
5. Diarrhea	Yes	No	_____
6. Troubled by Gas	Yes	No	_____
7. Trouble Swallowing	Yes	No	_____
8. Pain in Swallowing	Yes	No	_____
9. Poor Appetite	Yes	No	_____
10. Heartburn	Yes	No	_____
11. Stomach Pains	Yes	No	_____
12. Loss or Gain of Weight	Yes	No	_____
13. Vomiting	Yes	No	_____
14. Chest Pain	Yes	No	_____
15. Shortness of Breath	Yes	No	_____
16. Urinary Difficulties	Yes	No	_____
17. Skin Rashes	Yes	No	_____
18. Headaches	Yes	No	_____
19. Depression or Anxiety	Yes	No	_____
20. Bleeding Problems	Yes	No	_____
21. Joint Pain or Swelling	Yes	No	_____
22. Visual Changes	Yes	No	_____

Have you had any testing for the above complaints, such as x-rays or procedures?
Please list below with approximate dates (by letter(s)).

_____

_____

_____

_____

Have you had surgery? **Yes** or **No** (Please Circle)

Kind of Surgery_____ Hospital_____Year_____

_____

_____

_____

_____

_____

Do you require antibiotics before dental or surgical procedures? **Yes** **No**

If so, why? _____

_____

Do you smoke? Yes No

Do you use alcohol? Yes No

Have you smoked in the past? Yes No

If yes, for how long and when did you stop?_____

Have you used alcohol in the past? Yes No

If yes, for how long and when did you stop?_____

Do you drink coffee? Yes No

If yes, how much and how often?_____

WOMEN: Could you be pregnant at present? Yes No

THANK YOU!

YOUR SIGNATURE_____

☐ Medical Records Reviewed

☐ Ancillary Reports Reviewed

_____ _____

Physician Signature Date