HEALTH HISTORY QUESTIONNAIRE

Name:_____

Age:_____ DOB:_____ ☐ Male ☐ Female

Today's Date:_____ Reason for Visit:_____

ALLERGIES:_____

_____

Digestive Health Associates of Northern Michigan, P.C.

PAST HISTORY (✓ all that apply)

☐ Seizure_____
☐ Stroke / TIA_____
☐ Head Injury (when)_____
☐ Congestive Heart Failure_____
☐ Heart Attack (when)_____
☐ High Blood Pressure_____
☐ Bleeding ☐ Clotting Problem_____
☐ High Cholesterol_____
☐ Asthma ☐ Emphysema
☐ Hiatal Hernia ☐ Ulcer
☐ Liver Disease ☐ Hepatitis
☐ Ostomies
☐ Kidney Disease ☐ Kidney Stone
☐ Diabetes ☐ Hypoglycemia (low blood sugar)
☐ Thyroid Problems
☐ Arthritis ☐ Limited Motion
☐ HIV ☐ AIDS
☐ Cancer / Tumor (site)_____
☐ Chemotherapy / Radiation_____
☐ Depression ☐ Alcoholism
☐ Suicide Attempt
☐ Chronic Pain

LIST HOSPITALIZATIONS & SURGERIES (approximate dates):
(Please use back for additional info)

_____
_____
_____
_____
_____
_____
_____

MEDICINE (Type and Dosage)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS (Recently)

General Symptoms
☐ Fever ☐ Chills ☐ Night Sweats
☐ Fatigue
☐ Weight Loss > 5lbs
☐ Weight Gain > 5lbs
☐ Trouble Sleeping
☐ Pain (location)_____
_____

Neurologic
☐ Chronic Headache ☐ Migraines
☐ Dizziness ☐ Fainting_____
☐ Weakness ☐ Numbness_____

EENT
☐ Glasses ☐ Contacts ☐ Reading
☐ Recent change in vision
☐ Mouth Pain ☐ Sore Throat
☐ Hearing Difficulty
☐ Hearing Aids - ☐ R ☐ L ☐ Both

Cardiovascular
☐ Chest Pain_____
☐ Ankle Swelling_____
☐ Murmur ☐ Antibiotic needs?_____
☐ Palpitations ☐ Arrhythmias?_____
☐ Easy Bleeding ☐ Bruising
☐ Circulatory Problem

Pulmonary
☐ Breathing Problems_____
☐ Short of Breath_____
☐ Cough - Is it productive? Yes/No
☐ Mucus Changes
☐ Sleep Apnea ☐ CPAP_____
☐ TB-when were you last tested_____

Gastrointestinal-Hepatic
☐ Nausea ☐ Vomiting
☐ Abdominal Pain ☐ Bloating
☐ Diarrhea ☐ Constipation
☐ Black Stool ☐ Bloody Stool
☐ Ulcer ☐ Digestive Problem
☐ Reflux ☐ Swallowing Difficulty

Genitourinary
☐ Dialysis - last:_____
☐ Blood in urine
☐ Painful or difficult urination
☐ Frequent urination
☐ Sexually Transmitted Diseases

Female Reproductive
☐ Are you pregnant?
☐ Breast Discharge ☐ Breast Pain
☐ Vaginal Discharge
☐ Abnormal uterine bleeding

Endocrine
☐ Excessive Thirst
☐ Change in diet ☐ Change in appetite
☐ Change in activity_____

Skin
☐ Skin Rash ☐ Skin Sores
☐ Change in color of skin
☐ Swollen Skin ☐ Swollen Glands

Musculoskeletal
☐ Joint Pain ☐ Arthritis
☐ Limited Motion_____
☐ Back Pain ☐ Neck Pain
☐ Fractures ☐ Contractures
☐ Protheses_____
☐ Limb pain/swelling

Anesthesia/Surgical
☐ Is there any history of anesthesia problems? ☐ Y ☐ N
_____
☐ Family anesthesia problem_____
☐ Blood transfusion reaction_____

FAMILY HISTORY (List Family Member)
☐ Heart Disease_____
☐ Cancer_____
☐ Stroke_____
☐ Diabetes_____
☐ Other_____

SOCIAL HISTORY
Occupation?_____
☐ Smoke cigarettes? Pack(s) per day?_____
☐ For how long? When quit?_____
☐ Drink caffeine? Cups per day? _____
☐ Recreational drugs?_____
☐ Consume alcohol? _____
Frequency_____
For how long?_____ When quit?_____

REVIEWED BY_____ Date_____
_____
_____
_____
_____
_____
_____
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