

Health Questionnaire

Please complete both sides of this form and quickly return it to our office in the self addressed envelope provided. OR You may also download this form from our website at www.salemgastroenterology.com

We appreciate your timeliness in this matter, as it will help ensure an efficient visit with our physician.

Patient Name: _____ Date of Birth: _____ Reason for visit: _____

Are you **CURRENTLY** experiencing any of the following? **If answer is yes, please mark box with a check**

Gastrointestinal

- Acid Regurgitation
- Belching
- Black Tarry Stools
- Bloating
- Constipation
- Change in Bowel Habits
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Jaundice
- Abdominal Pain
- Nausea
- Poor Appetite
- Rectal Bleeding
- Vomiting

Heartburn

- Occurs at least 2-3 times a week.
- History of frequent heartburn at least 5-10 years.

General

- Currently Pregnant
- Fatigue
- Fever
- Unexplained Weight Loss

Neurologic

- Black Out Spells
- Blurred Vision
- Migraines
- Numbness
- Seizures
- Weakness

Musculoskeletal

- Arthritis
- Back Pain
- Muscle Disease
- Neck Pain

Hematologic

- Bleed Tendency
- Easy Bruising

Cardiac

- Chest Pain
- Chest pain occurs with exercise
- Chest pain occurs at rest
- Chest pain is due to heart problems
- Have been evaluated for chest pain
- Irregular Heartbeat

Respiratory

- Chronic Cough
- Hoarseness
- Shortness of Breath
- Wheezing

Genitourinary

- Bloody Urine
- Dark Urine
- Excess Thirst or Urination
- Pain on Urination

ENT

- Frequent Nosebleed
- Hearing Loss
- Loose Teeth

Skin

- Current Skin Rash
- Itching
- Skin Nodule
- Skin Ulcer

Psychosocial

- Alcoholism
- Anxiety
- Depression

Have you been diagnosed with the following? **If answer is yes, please mark box with a check.**

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Frequent Bladder Infection | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Any Implantable Stimulator | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Previous Stroke |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Colon/Rectal Cancer | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Using Home Oxygen? | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach Cancer |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> History of Tuberculosis | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Depression | <input type="checkbox"/> History of Blood Clots | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Exposure / Infection | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Implantable Defibrillator | |

List your medications with dosage and frequency below, or you may submit a separate Medication List. Also list any drug allergies and associated reactions below. **If none, please mark none.**

Yes, I give Salem Gastro permission to electronically check my prescription history.

Medication/Dosage/Frequency: **None** Drug Allergies and Reaction **None** (EXAMPLE: Protonix 40 mg once daily)

Have you had any of the following tests? Please select a time frame for each test below.

	Never	1-5 yrs ago	6-10 yrs ago	10+ yrs ago
Flex Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper GI X-Ray Series	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Surgical History: Please list the year of your surgery below, OR mark none if no history None

Appendectomy _____	Hysterectomy _____
Colon Resection _____	Liver Transplant _____
Gallbladder _____	Kidney Transplant _____
Heart Bypass _____	Tonsillectomy _____
Heart Valve _____	Ulcer _____
Hernia Repair _____	Other Surgeries: _____

Have **you** or any of **your blood relatives** had any of the following? If yes, please list their relation to you .

OR is family history **unknown** due to Adoption Estranged from family No knowledge of my family history

	YES	NO	Relation / Age of Diagnosis	Personal History
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Colon/Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Ovarian/Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Tobacco Never used tobacco

Alcohol Never used alcohol

Current use: _____ packs per day

Current use: _____ drinks per day _____ drinks per week

Prior use: Quit _____ months / years ago?

Prior use: Quit _____ months / years ago? _____ drinks per week

Recreational/Illegal Drugs Never used recreational/illegal drugs

Currently using: _____ How often? _____ Last used: _____

Previously used: _____ When? _____