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
- □ Spitting Up Blood

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
- □ Been evaluated for chest pain
- □ Irregular Heartbeat

Respiratory
- □ Chronic Cough
- □ Hoarseness
- □ Shortness of Breath
- □ Wheezing
- □ Using Home O_2
  - □ as needed □ night □ continuous

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.
- □ Anemia
- □ Anxiety Disorder
- □ Any Implantable Stimulator
- □ Artificial Joints
- □ Asthma
- □ Bleeding Disorder
- □ Crohn's Disease
- □ Colon Polyps
- □ Cancer - Colon/Rectal
- □ Cancer - Breast
- □ Cancer - Esophageal
- □ Cancer - Ovarian
- □ COPD
- □ Emphysema
- □ Depression
- □ Diabetes
- □ Diverticulosis
- □ Diverticulitis
- □ Frequent Bladder Infection
- □ Heart Disease
- □ Heart Attack
- □ Heart Failure
- □ Heart Murmur
- □ Hepatitis
- □ Hiatal Hernia
- □ High Blood Pressure
- □ High Cholesterol
- □ History of Tuberculosis
- □ History of Blood Clots
- □ Irritable Bowel Syndrome
- □ Kidney Failure/Requires Dialysis
- □ Kidney Disease
- □ Liver Disease
- □ Pacemaker
- □ Pancreatitis
- □ Previous Stroke
- □ Rheumatic Fever
- □ Seizure Disorder
- □ Sleep Apnea
- □ Stomach Cancer
- □ Thyroid Disorders
- □ Ulcerative Colitis
- □ Valve Replacement
- □ Implantable Defibrillator
- □ HIV Exposure / Infection

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	☐	☐	☐	☐
Colonoscopy	☐	☐	☐	☐
Upper Endoscopy	☐	☐	☐	☐
Upper GI X-Ray Series	☐	☐	☐	☐

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
☐ Bleeding Disorder	☐	☐		
☐ Breast Cancer	☐	☐		
☐ Esophageal Cancer	☐	☐		
☐ Celiac Disease	☐	☐		
☐ Colon Polyps	☐	☐		
☐ Colon/Rectal Cancer	☐	☐		
☐ Crohn's Disease	☐	☐		
☐ Liver Disease	☐	☐		
☐ Ovarian/Uterine Cancer	☐	☐		
☐ Pancreatic Cancer	☐	☐		
☐ Pancreatitis	☐	☐		
☐ Stomach Cancer	☐	☐		
☐ Ulcerative Colitis	☐	☐		

Tobacco ☐ Never used tobacco

Current use: _____ packs per day

Prior use: Quit _____ months / years ago?

Alcohol ☐ Never used alcohol

Current use: _____ drinks per day _____ drinks per week

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? _____