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Patient History

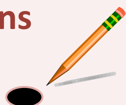
Please answer every question

Direction of Feed

STAFF: *Handwritten items must be entered* ***MANUALLY***.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

HEALTH HABITS AND SOCIAL HISTORY

TOBACCO

What is your smoking status? never ◯ previous ◯ current (every day) ◯ current (some days) ◯

How many cigarettes per day do you (or did you) **smoke?** occasional ◯ 10 ◯ 20 ◯ 30 ◯ 40+ ◯

Do you chew tobacco? yes ◯ no ◯

CAFFEINE

How many caffeine drinks do you have per day? occasional ◯ 1 ◯ 2 ◯ 3 ◯ 4+ ◯

ALCOHOL

Do you drink alcohol? no ◯ yes ◯

please fold on dotted line

If yes, how many drinks per day? occasional ◯ 1 ◯ 2 ◯ 3 ◯ 4+ ◯

NSAIDS

Do you take aspirin or other NSAIDs like Advil / Aleve / Motrin? in the past ◯ no ◯ yes ◯

If yes, how many tablets per day? occasional ◯ 1-3 ◯ 4-6 ◯ >6 ◯

EXERCISE

Do you exercise regularly? no ◯ yes ◯

EMPLOYMENT

employed ◯ retired ◯
unemployed ◯ student ◯
homemaker ◯ **occupation:** ____________________

OTHER

Do you have tattoos / body piercings? no ◯ yes ◯

Do you eat a high fiber diet? no ◯ yes ◯

Do you use a fiber supplement? no ◯ yes ◯

WOMEN

Are you pregnant or trying to conceive? yes ◯ no ◯

Are you breastfeeding? yes ◯ no ◯

Age 50-74: **Have you had a mammogram?** no ◯ yes ◯ **If yes, date:** ____________________

Age 60+: **Have you had a DXA scan** (bone density scan)**?** no ◯ yes ◯ **If yes, date:** ____________________

please fold on dotted line

Age 65+: **Have you experienced any urinary incontinence within the past 12 months?** no ◯ yes ◯

FAMILY MEDICAL HISTORY

◯ **FAMILY HISTORY UNKNOWN** ◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

Please indicate which family members have had these illnesses:	Mother	Father	Sister	Brother	Daughter	Son
Colon Cancer	◯	◯	◯	◯	◯	◯
Colon Polyps	◯	◯	◯	◯	◯	◯
Crohn's Disease / Ulcerative Colitis	◯	◯	◯	◯	◯	◯
Esophageal Cancer	◯	◯	◯	◯	◯	◯
Stomach Cancer	◯	◯	◯	◯	◯	◯
Liver Disease	◯	◯	◯	◯	◯	◯
Pancreatitis	◯	◯	◯	◯	◯	◯

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SAMPLE

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Patient History

Please answer every question

Direction of Feed

*STAFF: Handwritten items must be entered **MANUALLY**.*

MEDICAL HISTORY

Please indicate if you have ever had these conditions:

◯ I HAVE NO SIGNIFICANT MEDICAL HISTORY

	PRESENT	PAST		PRESENT	PAST	
GENERAL	◯	◯	Diabetes	◯	◯	High Cholesterol
	◯	◯	High Blood Pressure	◯	◯	Anemia
	◯	◯	Thyroid Disease	◯	◯	Lupus
	◯		HIV Positive	◯	◯	Cancer (please specify type): ____
	◯	◯	Arthritis			
HEART	◯	◯	Congestive Heart Failure	◯		Pacemaker
		◯	Bypass Surgery / Angioplasty	◯		Implantable Defibrillator
		◯	Vascular Surgery	◯		Artificial Heart Valve(s)
	◯	◯	Valve Disease		◯	Heart Attack (specify year): ____
	◯	◯	Atrial Fibrillation			

please fold on dotted line

	PRESENT	PAST		PRESENT	PAST	
LUNGS				◯	◯	Pneumonia
	◯	◯	Asthma	◯	◯	Emphysema / COPD
	◯	◯	Blood Clot in Lung	◯	◯	Sleep Apnea (diagnosed)
UROGENITAL				◯	◯	Kidney Stones
	◯	◯	Prostate Problems	◯	◯	Kidney Disease
GASTROINTESTINAL				◯	◯	Colon Polyps
	◯	◯	Acid Reflux (GERD)	◯	◯	Hemorrhoids
	◯	◯	Stomach Ulcers	◯	◯	Pancreatitis
	◯	◯	Diverticulosis	◯	◯	Gallstones
	◯	◯	Irritable Bowel Syndrome	◯	◯	Hepatitis
	◯	◯	Crohn's Disease	◯	◯	Liver Disease
	◯	◯	Ulcerative Colitis	◯	◯	Cirrhosis of the Liver
NEUROPSYCHIATRIC				◯	◯	Depression
		◯	Stroke	◯		Alzheimer's Disease
	◯	◯	Seizures	◯	◯	Alcoholism
	◯	◯	Migraines	◯	◯	Drug Abuse

SURGERIES

Please indicate if you have ever had these surgeries. Please indicate the year.

please fold on dotted line

◯ I HAVE HAD NO SURGERIES

◯ Appendix Removed ____

◯ Gallbladder Removed ____

◯ Uterus Removed ____

◯ Ovaries Removed ____

◯ Hemorrhoids Removed ____

◯ Gastric Bypass ____

◯ Hernia Repair ____

OTHER

Please list any other surgeries, illnesses, and medical conditions requiring hospitalization:

____

____

PREVENTIVE HEALTH

Please indicate if you have ever had these tests / vaccines. Please indicate the date.

YES	NO		DATE:
◯	◯	Flu Vaccine	____
◯	◯	Pneumonia Vaccine	____
◯	◯	Prostate Cancer Screen	____

YES	NO		DATE:
◯	◯	Colonoscopy	____
◯	◯	Flexible Sigmoidoscopy	____
◯	◯	Fecal Occult Blood Test	____

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