WACO GASTROENTEROLOGY ASSOCIATES—PATIENT HEALTH HISTORY, PART 1

Date: _____ **Name:** _____ **Date of Birth:** _____

Current Medications *(include any over the counter medicines, vitamins, supplements, & diet pills)*

Name	**Dose/Strength**	**When taken (daily, as needed, etc.)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES: _____

Pharmacy Preference: _____ Location: _____ Phone #: _____

Past Surgeries / Date

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a COLONOSCOPY previously? □ NO □ Yes (When? Where?) _____

Have you had an EGD (upper scope) previously? □ NO □ Yes (When? Where?) _____

CURRENT WEIGHT: _____ **HEIGHT:** _____ (*Staff use, BMI:* _____)

FAMILY HISTORY--*Mark box for any problems that run in your family and tell us what relative (circle M=mother, F=father, B=brother, S=sister)*

□ Colon polyps (M F B S)
□ Gastric polyps (M F B S)
□ Liver disease (M F B S)
□ Blood disorders (M F B S)
□ Pancreatitis (M F B S)
□ Ulcers (M F B S)
□ Other diseases (M F B S) Type: _____
□ Cancer (M F B S) Type: _____

SOCIAL HISTORY

Have you ever smoked? □ Yes □ No Do you currently smoke? □ Yes □ No

If yes, how number of packs per day? _____

Have you ever used alcohol? □ Yes □ No Do you currently use alcohol? □ Yes □ No

If yes, how much? □ Daily □ Weekly □ Monthly □ Other: _____

Have you ever used recreational drugs? □ Yes □ No Do you currently use? □ Yes □ No

COMMENTS

Info Charted by/Date: _____

WACO GASTROENTEROLOGY ASSOCIATES—PATIENT HEALTH HISTORY, PART 2

Date: _____ **Name:** _____ **Date of Birth:** _____

REVIEW OF SYSTEMS—*Please mark NO or YES for each item if you have the problem.*

NO/ YES

Constitutional
- □ □ Chills
- □ □ Fever
- □ □ Malaise/Fatigue
- □ □ Weight Loss

Head/Eyes/ENT
- □ □ Double vision
- □ □ Ear infections
- □ □ Eye pain
- □ □ Nasal congestion
- □ □ Sinus infection
- □ □ Sore throat

Respiratory
- □ □ Shortness of breath
- □ □ Frequent cough
- □ □ Painful breathing
- □ □ Wheezing
- □ □ Asthma

If yes, last attack _____

- □ □ Ever hospitalized for attack? When? _____
- □ □ Bronchitis
- □ □ Emphysema/COPD
- □ □ Home use of oxygen
- □ □ Pneumonia
- □ □ Prior airway difficulties
- □ □ Productive cough
- □ □ Recent URI
- □ □ Sleep Apnea
- □ □ If yes, CPAP?
- □ □ Tuberculosis

Cardiovascular
- □ □ Chest pain If yes,

Frequency: _____
Duration: _____
Last occurrence: _____
Caused by: _____
Occurs at rest? _____
What makes it go away? _____
_____

- □ □ Swelling in hands/feet
- □ □ Palpitations/irregular beat
- □ □ Cardiac stents

If yes, when? _____
Other intervention? _____

- □ □ Congestive heart failure

If yes, last episode _____
EF % _____

NO/ YES

Last visit to cardiologist/results of visit: _____
_____

- □ □ Heart attack

If yes, when? _____

- □ □ Heart valve disease
- □ □ High blood pressure
- □ □ Internal defibrillator
- □ □ Pacemaker
- □ □ Peripheral vascular disease

Gastrointestinal
- □ □ Abdominal pain
- □ □ Change in bowel habits
- □ □ Constipation
- □ □ Diarrhea
- □ □ Trouble swallowing
- □ □ Heartburn
- □ □ Vomiting blood
- □ □ Rectal bleeding
- □ □ Loss of appetite
- □ □ Blood in stool
- □ □ Nausea
- □ □ Reflux
- □ □ Vomiting
- □ □ Barretts
- □ □ Cirrhosis
- □ □ Colitis
- □ □ Colon polyps
- □ □ Crohns
- □ □ Diverticulosis
- □ □ Esophageal stricture
- □ □ Hemorrhoids
- □ □ Hepatitis
- □ □ Hiatal hernia
- □ □ Indigestion
- □ □ Irritable Bowel
- □ □ Peptic ulcer disease
- □ □ Ulcers
- □ □ Unexplained weight loss

Genitourinary
- □ □ Burning with urination
- □ □ Blood in urine
- □ □ Urinary frequency
- □ □ Urinary incontinence
- □ □ Urinary retention
- □ □ Dialysis
- □ □ Kidney disease
- □ □ Kidney stones

NO/ YES

- □ □ Renal insufficiency

Endocrine
- □ □ Cold intolerance
- □ □ Excessive thirst
- □ □ Heat intolerance
- □ □ Diabetes
- □ □ Thyroid disease

Neurological
- □ □ Dizziness
- □ □ Headache
- □ □ Numbness
- □ □ Tremors
- □ □ Vertigo
- □ □ Accident/head injury
- □ □ Alzheimer's disease
- □ □ Amputation
- □ □ Dementia
- □ □ Multiple sclerosis
- □ □ Neuromuscular disease
- □ □ Paralysis
- □ □ Parkinson's disease
- □ □ Seizures
- □ □ Stroke

If yes, when _____
Any residual/weakness _____

Psychiatric
- □ □ Anxiety
- □ □ Depression
- □ □ Increased stress
- □ □ Bipolar
- □ □ Schizophrenia
- □ □ Other psych disorder

Skin
- □ □ Contact allergy
- □ □ Hives
- □ □ Itching of skin
- □ □ Rash

Musculoskeletal
- □ □ Back pain
- □ □ Muscle pain
- □ □ Joint Pain
- □ □ Artificial joint/prosthetic
- □ □ Restless leg syndrome

Hematologic
- □ □ Easy bleeding
- □ □ Bleeding disorder
- □ □ Easy bruising
- □ □ Swollen lymph nodes

NO/ YES

- □ □ Chemicals in workplace
- □ □ Food allergies
- □ □ Immunosuppression
- □ □ Seasonal allergies

Reproductive

Males Only:
- □ □ Penile discharge
- □ □ Sexual dysfunction

Females Only:
- □ □ Breast lumps
- □ □ Breast pain
- □ □ Vaginal discharge
- □ □ Hysterectomy
- □ □ Menopause

Last Menstrual Cycle: _____

- □ □ Tubal ligation

Fall Risk Assessment
- □ □ Falls, when? _____
- □ □ Hip/knee replacement in the last six months?
- □ □ Unsteady gait
- □ □ Use of assistive device (Type: _____)

General
- □ □ Allergic to eggs
- □ □ Anemia
- □ □ Anesthesia complications in past?
- □ □ Auto immune cancer
- □ □ Cancer
- □ □ Chemotherapy
- □ □ Difficult intubation start (breathing tube)
- □ □ Difficult IV start
- □ □ Do you take antibiotics prior to dental work?
- □ □ HIV/AIDS
- □ □ Infectious disease: Type: _____
- □ □ Lupus
- □ □ Missing, chipped/loose teeth or dentures?
- □ □ Recent fever or cold-like symptoms
- □ □ Recent illness, infection or exposure
- □ □ Take prescription diet pills

Info Charted by/Date: _____