Digestive Disease Associates of Rockland
A Division of Allied Digestive Health

Medical History Questionnaire

Primary physician: _____

Referring physician: _____

Last Name: _____ First Name: _____

Age: _____ DOB: ____/____ /____ □ Male □ Female Height:_____ Weight:_____ lbs

Reason for visit today: _____

_____

_____

_____

Preferred Pharmacy	Preferred Lab	Allergies
Name: _____ Location: _____ Tel #: _____	□ Quest □ Labcorp □ Shiel □ Bioreference □ Other: _____	□ No Known Drug Allergies □ 1. _____ □ Soy allergy □ 2. _____ □ Egg allergy □ 3. _____ □ Latex allergy

Current Medications:

Medication Name	Dose / How often		Medication Name	Dose / How often

Previous Immunizations

□ None	□ Influenza, date: _____	□ Hepatitis A, date: _____	□ Hepatitis B, date: _____

Previous Diagnostic Tests: please indicate when and where your tests were done:

□ **Endoscopy (EGD)**	□ **Colonoscopy**
When: _____ Where:_____ Result: _____	When: _____ Where:_____ Result: _____

Past or Present Medical Conditions: please check all that apply.

Cardiac/Heart	□ High blood pressure □ Heart Failure □ Heart attack □ Chest pain/Angina	□ High cholesterol □ Atrial Fibrillation □ Anticoagulant therapy	□ Cardiac stent □ Pacemaker □ Defibrillator □ Artificial heart valve	□ Heart murmur □ Blood Clot/DVT □ Other: _____
Pulmonary/ Lungs	□ Asthma □ COPD □ Emphysema □ Sleep apnea	□ Pneumonia □ Lung cancer □ Tuberculosis □ Positive TB test	□ Use CPAP at home □Use oxygen at home	□ Other: _____ _____
Endocrine	□ Diabetes	□ Hypothyroid	□ Hyperthyroid	□ Other:
Renal/Kidney	□ Urinary tract infection □ Kidney stones	□ Kidney failure □ Dialysis		□ Other:
Intestinal/ Liver	□ Acid reflux □ Hiatal hernia □ Barrett's esophagus □ Peptic ulcer □ Celiac Disease	□ Colon cancer □ Colon polyps □ Diverticulitis □ Ulcerative colitis □ Crohn's disease	□ Gallstones □ Pancreatitis □ Fatty Liver □ Cirrhosis □ Hepatitis B □ Hepatitis C	□ Irritable bowel syndrome □ Other_____ _____ _____
Hematology/ Oncology	□ Anemia □ Low iron levels □ Bleeding disorder	□ On chemotherapy □ Radiation therapy □ Taking blood thinner	□ Cancer, type: _____ _____	□ Blood transfusion □ Other _____
Rheumatology	□ Rheumatoid arthritis □ Lupus	□ Scleroderma □ Sjogren's	□ Fibromyalgia □ On steroids	□ Other: _____
Mental Health	□ Depression □ Anxiety	□ Bipolar disorder □ Schizophrenia	□ Alcohol abuse □ Anorexia/Bulimia	□ Other: _____
Neurology	□ Stroke □ TIA	□ Seizure/Epilepsy □ Multiple sclerosis	□ Memory loss □ Migraine headaches	□ Other: _____
Gynecology	□ Last Menstrual Period: _____	□ Post-menopausal	□ Hysterectomy	□ Tubal ligation
Orthopedic	□ Chronic back pain □ Herniated disc	□ Scoliosis	□ Fractures: _____	□ Other:

Previous Surgeries:	**□ No prior surgeries**	
□ Gallbladder removed, date:	All other surgeries:	Date:
□ Appendix removed, date:	1.	
□ Colon surgery, date:	2.	
□ Small bowel resection, date:	3.	
□ Gastric lap band, date:	4.	
□ Gastric bypass/sleeve, date:	5.	
□ Hysterectomy, date:	7.	
□ Caesarian section, date(s):	8.	
□ Heart bypass surgery, date:	9.	
□ Heart valve surgery, date:	10.	

Family History									
□ No Knowledge of Family History									
Health Status:	**Father**	**Mother**	**Brother**	**Sister**	**Children**	**Paternal Grandfather**	**Paternal Grandmother**	**Maternal Grandfather**	**Maternal Grandmother**
Alive	□	□	□	□	□	□	□	□	□
Deceased/Age	□ _____	□ ___	□ ___	□ ___	□ _____	□ _____	□ _____	□ _____	□ ___
Colon Polyps	□	□	□	□	□	□	□	□	□
Colon Cancer	□	□	□	□	□	□	□	□	□
Esophageal cancer	□	□	□	□	□	□	□	□	□
Stomach cancer	□	□	□	□	□	□	□	□	□
Pancreatic cancer	□	□	□	□	□	□	□	□	□
Liver cancer	□	□	□	□	□	□	□	□	□
Crohn's disease	□	□	□	□	□	□	□	□	□
Ulcerative colitis	□	□	□	□	□	□	□	□	□
Celiac disease	□	□	□	□	□	□	□	□	□
Liver disease	□	□	□	□	□	□	□	□	□
Heart Attack	□	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□	□
Breast Cancer	□	□	□	□	□	□	□	□	□
Other Cancer	□	□	□	□	□	□	□	□	□

Social History	
General	Occupation: _____ □ Retired
Marital Status	□ Single □ Married □ Divorced □ Separated □ Widowed □ Civil Union
Alcohol Use	□ None □ Yes: Type _____ Amount_____ How Often: _____
Caffeine Use	□ None □ Coffee: ___ cups/day □ Tea: ____ cups/day □ Soda ____ cans / day
Tobacco Use	□ Never smoked □ Former Smoker, quit ____ years ago □ Current smoker: _____ cigarettes/day □ Pipe / cigar use
Drug Use	□ None □ Cocaine, How often_____ □ Marijuana, How often_____ □ Intravenous drugs, How often_____

Review of Symptoms

Please Check **Yes** or **No** according to your present condition:

Constitutional	**Yes**	**No**	**Gastrointestinal**	**Yes**	**No**	**Hematologic/Lymphatic**	**Yes**	**No**
Fatigue	□	□	Abdominal Pain	□	□	Easy Bruising	□	□
Fever or Chills	□	□	Abdominal distension	□	□	Prolonged bleeding	□	□
Loss of Appetite	□	□	Gas/Bloating	□	□			
Weight Gain	□	□	Excessive belching	□	□	**Skin**		
Weight Loss	□	□	Heartburn	□	□	Itching	□	□
			Indigestion	□	□	Rashes	□	□
Allergic/Immunological			Regurgitation of food	□	□	New Lesions	□	□
HIV Exposure	□	□	Difficulty swallowing	□	□			
Persistent Infections	□	□	Nausea	□	□	**Neurologic**		
Strong Allergic Reactions	□	□	Vomiting	□	□	Dizziness, lightheaded	□	□
Hives	□	□	Fullness after meals	□	□	Frequent headaches	□	□
			Vomiting blood	□	□	Numbness or tingling	□	□
Cardiovascular			Black stools	□	□	Seizures	□	□
Chest pain / tightness	□	□	Change in bowel habits	□	□	Difficulty with memory	□	□
Irregular Heartbeat	□	□	Diarrhea	□	□	Blurred vision	□	□
Palpitations	□	□	Constipation	□	□	Weakness in arms or legs	□	□
Leg swelling/Edema	□	□	Fatty food intolerance	□	□			
			Lactose intolerance	□	□	**Urinary**		
			Rectal pain	□	□	Frequent urination	□	□
Respiratory			Rectal bleeding	□	□	Urination at night	□	□
Chronic Cough	□	□	Blood in stool	□	□	Blood in urine	□	□
Shortness of Breath	□	□	Hemorrhoids	□	□			
Wheezing	□	□	Soiling or incontinence	□	□	**Joints/Muscle**		
Painful Respiration	□	□	Jaundice	□	□	Backaches	□	□
						Joint pain/swelling	□	□
Mental Health			**Head & Neck**			Weakness	□	□
Anxiety	□	□	Change in Vision	□	□			
Depression	□	□	Hearing Problem	□	□	**Hormonal**		
			Nose/Gum Bleeding	□	□	Hot flashes	□	□
			Sinusitis	□	□	Flushing	□	□
			Hoarseness	□	□	Heat/cold Intolerance	□	□
			Sore Throat	□	□			

Patient's Signature: _____ Date: _____