BaylorScott&White
CENTER FOR INFLAMMATORY BOWEL DISEASES
DALLAS
A member of HealthTexas Provider Network

Name: ______________________
DOB: ______________________
Date: ______________________

Health History Form: Follow-up Patient

Thank you for choosing our clinic for your healthcare needs! We appreciate your assistance with completing this form, as it will help us better care for you. This is confidential information to be kept in your electronic medical record. Please speak with your physician or nurse if you need assistance with this form.

Who is your referring physician? ____

Who is your primary care physician? ____

Who is your gastroenterologist? ____

What is the reason for your visit/most bothersome symptom? ____________________________________
____

What are your greatest worries and fears about your condition? ______________________________
____

Have you been hospitalized for your disease since your last visit? If yes, please list the reason(s) and date(s); ex. Flare, blockage, abscess, surgery, etc. ____________________________________
____

What is your Diagnosis?

__ Crohn's Disease
__ Microscopic colitis
__ Celiac disease

__ Ulcerative colitis
__ Pouchitis
__ Other: ___________________

Date of Diagnosis
___/___/______

Please complete if you have Crohn's Disease. **YESTERDAY**, how did you feel in terms of?	Please complete if you have ulcerative colitis. Answer on the basis of the **PAST 3 DAYS**
General well-being: ☐ Very well ☐ slightly below par ☐ poor ☐ very poor ☐ terrible Abdominal pain: ☐ None ☐ mild ☐ moderate ☐ severe Number of liquid stools over past 24 hours: ___ Are you having any? ☐ Mouth ulcers ☐ Skin lesions ☐ Inflamed joints ☐ Anal sores ☐ Inflamed eyes	On average, have many stools are you having daily? ☐ Normal ☐ 1-2 stools/day more than normal ☐ 3-4 stools/day more than normal ☐ 5 stools/day more than normal On average, how much rectal bleeding are you having? ☐ None ☐ Visible blood with stool less than half the time ☐ Visible blood with stool half of the time or more ☐ Passing blood alone

SF-12® QUALITY OF LIFE Patient Questionnaire

This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by placing a check mark on the line in front of the appropriate answer. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:
_____ Excellent (1)
_____ Very Good (2)
_____ Good (3)
_____ Fair (4)
_____ Poor (5)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:
_____ Yes, Limited A Lot (1)
_____ Yes, Limited A Little (2)
_____ No, Not Limited At All (3)

3. Climbing SEVERAL flights of stairs:
_____ Yes, Limited A Lot (1)
_____ Yes, Limited A Little (2)
_____ No, Not Limited At All (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:
_____ Yes (1)
_____ No (2)

5. Were limited in the KIND of work or other activities:
_____ Yes (1)
_____ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:
_____ Yes (1)
_____ No (2)

7. Didn't do work or other activities as CAREFULLY as usual:
_____ Yes (1)
_____ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?
_____ Not At All (1)
_____ A Little Bit (2)
_____ Moderately (3)
_____ Quite A Bit (4)
_____ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

10. Did you have a lot of energy?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

11. Have you felt downhearted and blue?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

12. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

<u>Medications</u> Please list your CURRENT MEDICATIONS or attach a list of current medications: (Include herbal medications, dietary supplements, vitamins, Tylenol, Ibuprofen, injectables/infusions, and other over-the-counter medications)

Medication name	Dose and frequency

At the present time, are you having any of the following symptoms:

General	□ fever □ night sweats □ fatigue	□ weight gain □ weight loss	Joint	□ pain □ stiffness
Head	□ eye pain □ eye redness	□ mouth sores	**Skin**	□ painful rashes □ skin ulcers
Chest	□ chronic cough □ shortness of breath	□ wheezing	**Vascular**	□ swelling in the feet □ calf pain with walking
Heart	□ palpitations □ chest pain with activity	□ chest pain at rest □ fainting	**Endocrine**	□ heat intolerance □ cold intolerance
GI	□ heartburn □ acid reflux □ pain with swallowing □ food sticking with swallowing □ abdominal pain □ distended distention □ fear of eating □ gurgling bowel sounds □ nausea □ vomiting □ loose stool □ rectal bleeding	□ urgent bowel movements □ false alarms of the rectum (urges to go but without producing any significant amount of stool) □ inability to pass gas (fear of passing stool) □ black stool □ anal pain □ pain around the anus □ swelling around the anus □ anal discharge □ jaundice □ itching □ milk intolerance	**Neurologic**	□ headaches □ weakness (face/extremities) □ numbness (face/extremities) □ problems with vision
			Women	□ irregular periods □ painful intercourse □ infertility □ passing stool or gas through the vagina
			Men	□ infertility □ erectile dysfunction
Genitourinary	□ kidney stones □ blood in urine □ stool in urine	□ pain/burning with urination □ frequent urination	**Psychiatric**	□ anxiety □ depression

Please list any health concerns, or any other items you would like to discuss with the doctor:

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