Health History Questionaire

Who referred your consultation?

If no one referred you, how did you hear about us?

Who is your primary care physician?

Have you ever seen a gastroenterologist? Please list their name(s).

☐ Yes, I am under the care of a gastroenterologist.

☐ Yes, I have seen one in the past, but not currently.

☐ No, I have never seen a gastroenterologist.

Please list your preferred pharmacy

What is your primary concern for today's visit?

Have you recently experienced any of the following? (Please check all that apply)

☐ Trouble Swallowing  ☐ Weight Loss  ☐ Abdominal Bloating
☐ Food Gets Stuck  ☐ Weight gain  ☐ Abdominal pain
☐ Choking  ☐ Change in appetite  ☐ Recent change in bowel habits
☐ Heartburn  ☐ Feeling full early  ☐ Diarrhea
☐ Nausea  ☐ Sore Throat  ☐ Constipation
☐ Vomiting  ☐ Voice Hoarseness  ☐ Black Tar-like stools
☐ Regurgitation  ☐ Congestion  ☐ Bleeding from rectum
☐ Belching  ☐ Throat Clearing  ☐ Vomiting Blood

☐ Fevers or chills  ☐ Shortness of breath  ☐ Heat or cold intolerance
☐ Fatigue  ☐ Difficulty breathing  ☐ Trouble with urination
☐ Headaches  ☐ Cough  ☐ Frequency of urination
☐ Dizziness  ☐ Chest Pain  ☐ Joint pain or swelling
☐ Blurry Vision  ☐ Palpitations  ☐ Recent mood changes
☐ Double vision  ☐ Yellowing of eyes or skin  ☐ Memory changes
☐ Hearing changes  ☐ Skin rashes or lumps  ☐ Frequently anxious
Have you ever been treated for or had issues with any of the following? (Please check all that apply)

- [ ] Cancer: ____________
- [ ] Ulcers
- [ ] Back/Spinal problems
- [ ] Hay fever
- [ ] Chronic Diarrhea
- [ ] Kidney Stones
- [ ] Food allergies
- [ ] Colon Polyps
- [ ] Other Kidney Problems
- [ ] Heart Attack
- [ ] Diverticulosis/Diverticulitis
- [ ] Goiter or thyroid trouble
- [ ] Irregular Heartbeat
- [ ] Irritable or spastic colon
- [ ] Diabetes
- [ ] Valvular heart disease
- [ ] Colitis
- [ ] Other Kidney Problems
- [ ] Congestive Heart Failure
- [ ] Gallstones
- [ ] Blood clot in lungs or legs
- [ ] High blood pressure
- [ ] Pancreatitis
- [ ] Other blood disorders
- [ ] High cholesterol
- [ ] Hepatitis
- [ ] Poor Circulation
- [ ] Pneumonia
- [ ] Other Liver Disease
- [ ] Arthritis
- [ ] Asthma
- [ ] Genital Disorders
- [ ] Stroke
- [ ] Empysema or Bronchitis
- [ ] Prostate Trouble
- [ ] Seizures
- [ ] Other lung disease
- [ ] Endometriosis
- [ ] Depression or Anxiety

Have you every had the following operations? (Please check all that apply)

- [ ] Removal of gallbladder
- [ ] Removal of appendix
- [ ] Tonsillectomy
- [ ] Fundoplication
- [ ] Hemorrhoid Surgery
- [ ] Prostate surgery
- [ ] Antireflux surgery
- [ ] Removal of part/all of colon
- [ ] Hysterectomy
- [ ] Hiatal hernia repair
- [ ] Removal of Spleen
- [ ] Ovaries Removed
- [ ] Gastric sleeve
- [ ] Heart Bypass
- [ ] Tubes tied
- [ ] Gastric bypass
- [ ] Angioplasty
- [ ] Placement of artificial joint
- [ ] Lap Band placement
- [ ] Removal of Kidney
- [ ] Eye Surgery
- [ ] Myotomy for Achalasia
- [ ] Removal of Kidney
- [ ] Artificial blood vessel graft
- [ ] Replacement of Heart Valve
- [ ] Removal of stomach
- [ ] Inguinal hernia repair
- [ ] Any other surgery on the esophagus or stomach

Have you every had the following procedures (Please check all that apply)

- [ ] Upper endoscopy (a lighted camera that goes into your mouth usually while you are sedated)
- [ ] Barium Swallow or Esophagram (You drink barium and are placed in different positions for X ray pictures)
- [ ] Esophageal motility study (a catheter that goes through your nose and you drink at least 10 sips of salty water)
- [ ] Esophageal pH catheter based monitoring (a catheter that goes in your nose and monitors acid for 24 hours)
- [ ] Esophageal pH wireless monitoring (a capsule attached to your esophageal lining to monitor acid)
- [ ] Colonoscopy

Please list any other medical conditions or operations:
Please list any food or drug allergies and the reaction:

________________________________________________________________________

________________________________________________________________________

Please list all medications you currently take or provide your current medication list on another sheet:

Name, Dose, and Frequency of Medication:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please circle yes or no for each of the following questions.

Are you on medications for diabetes?  
Yes  No

Are you on steroids?  
Yes  No

Are you on any blood thinners?  
Yes  No

Are you currently taking an acid suppression tablet regularly?  
Yes  No

Have you ever been told you have a difficult airway or intubation?  
Yes  No

Have you ever had a problem with anesthesia. Please explain.  
________________________________________________________________________

Do you have sleep apnea or do you currently use a CPAP machine?  
Yes  No

Family History

Please list any significant medical condition

Father:  □ Alive □ Deceased  Medical Problems/Cause of Death: ____________________________

Mother: □ Alive □ Deceased  Medical Problems/Cause of Death: ____________________________

Number of Siblings: ____________  Sisters  Brothers

Number of Children: ____________  Sons  Daughters

Is there any family history of the following? Please list the family member.

Esophageal Cancer  Heart Disease

Stomach Cancer  Diabetes

Colon Cancer  Breast Ovary Endometrial or Uterine Cancer

Eosinophilic Esophagitis  Other cancers

Celiac Disease

Liver Disease

Pancreatic Disease

Ulcerative Colitis

Crohn's Disease
Social History
Please list your current marital status: __________________________

Who lives at home with you? __________________________

What is the highest level of education you have achieved?
□ Some School □ Some College □ Masters or Doctorate Degree
□ Highschool □ College Degree

In regards to school or work, check all that apply:
□ Working full time □ Stay at home parent / caregiver □ In School
□ Working part time □ Retired

What is your occupation / trade? __________________________

Tobacco
Have you used tobacco products?
□ Never smoked □ Current user □ Former user

Types of Tobacco used (check all that apply):
□ Cigarette □ Chewing products
□ Cigars □ Vapor

If you are a current tobacco user, how often do you use tobacco?

If you are a current tobacco user, how often do you use tobacco in a day?

If you are a former tobacco user, how long has it been since your last use?

How many years have you used tobacco?

Alcohol
Have you had a drink with alcohol in the past year?
□ No □ Yes

If yes, How often have you had a drink containing alcohol in the past year?
□ Never □ Monthly or Less □ 2 - 4 Times a month □ 2 - 3 Times a week □ 4 or More Times a Week

If yes, how many drinks did you have on a typical day when you were drinking?

If yes, please check all types of alcohol that was consumed:
□ Beer □ Wine □ Hard Liquor

Drugs
Do you smoke Marijuana?
□ No □ Yes

If so, how frequently?

Do you use any other illicit drugs? Please list:

Have you used any IV drugs (requiring a needle)? Please list:

Do you have any tattoos?
□ No □ Yes

Do you have any piercings?
□ No □ Yes

Where?

Signature: __________________________ Date: __________________________