



Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Date: \_\_\_\_\_

**Health History Form: New 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**  
 \_\_\_/\_\_\_/\_\_\_\_

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

**Have you ever been treated with any of the following medications?**

Prednisone	<input type="checkbox"/> Yes	Dates: _____	Remicade	<input type="checkbox"/> Yes	Dates: _____
Mesalamine	<input type="checkbox"/> Yes	Dates: _____	Humira	<input type="checkbox"/> Yes	Dates: _____
Entocort	<input type="checkbox"/> Yes	Dates: _____	Cimzia	<input type="checkbox"/> Yes	Dates: _____
Uceris	<input type="checkbox"/> Yes	Dates: _____	Simponi	<input type="checkbox"/> Yes	Dates: _____
Mercaptopurine	<input type="checkbox"/> Yes	Dates: _____	Tysabri	<input type="checkbox"/> Yes	Dates: _____
Azathioprine (Imuran)	<input type="checkbox"/> Yes	Dates: _____	Entyvio	<input type="checkbox"/> Yes	Dates: _____
Methotrexate	<input type="checkbox"/> Yes	Dates: _____	Stelara	<input type="checkbox"/> Yes	Dates: _____
Flagyl (Metronidazole)	<input type="checkbox"/> Yes	Dates: _____	TPN	<input type="checkbox"/> Yes	Dates: _____
Ciprofloxacin (Cipro)	<input type="checkbox"/> Yes	Dates: _____	Loperamide (Imodium)	<input type="checkbox"/> Yes	Dates: _____
Rifaximin	<input type="checkbox"/> Yes	Dates: _____	Diphenoxylate (Lomotil)	<input type="checkbox"/> Yes	Dates: _____
Pain Medication:	_____		Experimental Drug:	_____	
Probiotics:	_____		Other medications:	_____	

**Medications** 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

**Pharmacy** Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address or Cross Street \_\_\_\_\_ City \_\_\_\_\_

**Allergies** (foods and drugs)

Please indicate the type of reaction next to each.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History Problems** (check all that apply and indicate date of diagnosis)

- |  |               |   |               |
|--|---------------|---|---------------|
| <input type="checkbox"/> Melanoma            | (Date: _____) | <input type="checkbox"/> Heart attack           | (Date: _____) |
| <input type="checkbox"/> Other skin cancer   | (Date: _____) | <input type="checkbox"/> Heart arrhythmia       | (Date: _____) |
| <input type="checkbox"/> Broken bone(s)      | (Date: _____) | <input type="checkbox"/> Heart failure          | (Date: _____) |
| <input type="checkbox"/> Osteopenia          | (Date: _____) | <input type="checkbox"/> Stroke                 | (Date: _____) |
| <input type="checkbox"/> Osteoporosis        | (Date: _____) | <input type="checkbox"/> Emphysema/COPD         | (Date: _____) |
| <input type="checkbox"/> Mononucleosis       | (Date: _____) | <input type="checkbox"/> Asthma                 | (Date: _____) |
| <input type="checkbox"/> Chickenpox          | (Date: _____) | <input type="checkbox"/> Pancreatitis           | (Date: _____) |
| <input type="checkbox"/> Shingles            | (Date: _____) | <input type="checkbox"/> Kidney Disease         | (Date: _____) |
| <input type="checkbox"/> Abnormal Pap smear  | (Date: _____) | <input type="checkbox"/> Tuberculosis           | (Date: _____) |
| <input type="checkbox"/> Diabetes            | (Date: _____) | <input type="checkbox"/> Depression             | (Date: _____) |
| <input type="checkbox"/> High blood pressure | (Date: _____) | <input type="checkbox"/> Other psychiatric      | (Date: _____) |
| <input type="checkbox"/> Multiple sclerosis  | (Date: _____) | <input type="checkbox"/> Anemia                 | (Date: _____) |
| <input type="checkbox"/> Lupus               | (Date: _____) | <input type="checkbox"/> Vitamin D deficiency   | (Date: _____) |
| <input type="checkbox"/> Thyroid disease     | (Date: _____) | <input type="checkbox"/> Vitamin B12 deficiency | (Date: _____) |

Please explain any items you checked and list any medical problems not included:

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**Past Surgical History**

Please list all surgeries including dates.

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**Complications:** (check all that apply and include the date of diagnosis)

- |                                      |               |  |               |
|--------------------------------------|---------------|--|---------------|
| Swollen, painful joints              | (Date: _____) | Primary sclerosing cholangitis   | (Date: _____) |
| Pain and stiffness in spine and hips | (Date: _____) | Hepatitis, Type <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | (Date: _____) |
| Joint pain without swollen joints    | (Date: _____) | Other liver disease: _____   | (Date: _____) |
| Painful, red, skin rashes            | (Date: _____) | Recurrent mouth sores  | (Date: _____) |
| Ulcerated skin sores                 | (Date: _____) | Perianal fistula   | (Date: _____) |
| Psoriasis                            | (Date: _____) | Perianal abscess   | (Date: _____) |
| Uveitis (eye pain)                   | (Date: _____) | Rectovaginal fistula   | (Date: _____) |
| Episcleritis (red eyes)              | (Date: _____) | Deep vein thrombosis   | (Date: _____) |
|                                      |               | Pulmonary embolism   | (Date: _____) |
|                                      |               | Pneumonia  | (Date: _____) |

Please list any complications not included: \_\_\_\_\_

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**Menstrual Status:**

- Regular     Irregular     Perimenopausal/Postmenopausal     Hysterectomy

Last Menstrual Cycle (if applicable): \_\_\_/\_\_\_/\_\_\_\_\_

**Family Medical History**
 No knowledge of family history     Adopted

Relation	Age	Medical Problems	If deceased, cause of death	Age of death
Father _____	_____	_____	_____	_____
Father's Father	_____	_____	_____	_____
Father's Mother	_____	_____	_____	_____
Mother _____	_____	_____	_____	_____
Mother's Father	_____	_____	_____	_____
Mother's Mother	_____	_____	_____	_____
Brother / Sister				
Brother / Sister				
Brother / Sister				
Other: _____				

Diagnoses	Father	Mother	Brother	Sister	Grandfather	Grandmother	Other
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other diseases that run in the family: \_\_\_\_\_

**Social History****Marital Status:**
 Single    Married    Divorced

How many children do you have? \_\_\_\_\_

Have you traveled outside the United States in the past two years?

 Yes, where? \_\_\_\_\_    No
**Ashkenazi Jewish Ancestry:**
 Yes                       No
**Employment:**
 retired    unemployed    employed  
 disability    homemaker    student

What is your current/previous occupation?

\_\_\_\_\_

**Education:**
 grade school    some high school  
 graduated high school    GED    some college  
 graduated college    post-graduate school

Have you ever been abused?                       No    Physically    Sexually    Emotionally

**Risk Factors****Tobacco/Smoking Status:**
 Current every day smoker                       Former smoker  
 Current someday smoker                       Never smoker

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

How many cigarettes daily? \_\_\_\_\_

**Alcohol:**    Never    Former    Socially    Daily

How many drinks daily? \_\_\_\_\_

 Beer    Wine    Liquor

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

**Recreational/street drugs:**
 Never    Former    Daily   Type: \_\_\_\_\_

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

<b>General</b> <input type="checkbox"/> fever <input type="checkbox"/> night sweats <input type="checkbox"/> fatigue	<input type="checkbox"/> weight gain <input type="checkbox"/> weight loss	<b>Joint</b> <input type="checkbox"/> pain <input type="checkbox"/> stiffness
<b>Head</b> <input type="checkbox"/> eye pain <input type="checkbox"/> eye redness	<input type="checkbox"/> mouth sores	<b>Skin</b> <input type="checkbox"/> painful rashes <input type="checkbox"/> skin ulcers
<b>Chest</b> <input type="checkbox"/> chronic cough <input type="checkbox"/> shortness of breath	<input type="checkbox"/> wheezing	<b>Vascular</b> <input type="checkbox"/> swelling in the feet <input type="checkbox"/> calf pain with walking
<b>Heart</b> <input type="checkbox"/> palpitations <input type="checkbox"/> chest pain with activity	<input type="checkbox"/> chest pain at rest <input type="checkbox"/> fainting	<b>Endocrine</b> <input type="checkbox"/> heat intolerance <input type="checkbox"/> cold intolerance
<b>GI</b> <input type="checkbox"/> heartburn <input type="checkbox"/> acid reflux <input type="checkbox"/> pain with swallowing <input type="checkbox"/> food sticking with swallowing <input type="checkbox"/> abdominal pain <input type="checkbox"/> distended distention <input type="checkbox"/> fear of eating <input type="checkbox"/> gurgling bowel sounds <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> loose stool <input type="checkbox"/> rectal bleeding		<b>Neurologic</b> <input type="checkbox"/> headaches <input type="checkbox"/> weakness (face/extremities) <input type="checkbox"/> numbness (face/extremities) <input type="checkbox"/> problems with vision
<b>Genitourinary</b> <input type="checkbox"/> kidney stones <input type="checkbox"/> blood in urine <input type="checkbox"/> stool in urine		<b>Women</b> <input type="checkbox"/> irregular periods <input type="checkbox"/> painful intercourse <input type="checkbox"/> infertility <input type="checkbox"/> passing stool or gas through the vagina
<input type="checkbox"/> pain/burning with urination <input type="checkbox"/> frequent urination		<b>Men</b> <input type="checkbox"/> infertility <input type="checkbox"/> erectile dysfunction
<b>Psychiatric</b> <input type="checkbox"/> anxiety <input type="checkbox"/> depression		

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

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## Preventative Care

### **Colon Cancer Screening** (for patients over 50)

Have you ever had colon cancer screening?  Yes  No

Colonoscopy?

When: \_\_\_/\_\_\_/\_\_\_\_\_  Normal  Abnormal

### **Osteoporosis** (bone thinning/weakening)

Have you ever had a bone density exam?  Yes  No

When: \_\_\_/\_\_\_/\_\_\_\_\_

Normal  Osteopenia  Osteoporosis

### **Immunizations**

When was your **last flu vaccine**? \_\_\_\_\_

Have you ever received a **pneumonia vaccine** (Pneumovax)?  Yes, When? \_\_\_\_\_  No

Have you ever received a **Hepatitis A vaccine**?  
 Yes, When? \_\_\_\_\_  No

Have you ever received a **Hepatitis B vaccine**?  
 Yes, When? \_\_\_\_\_  No

Have you ever received a **Shingles vaccine**?  
 Yes, When? \_\_\_\_\_  No

Have you ever had a **tuberculosis skin test**?  
 Yes, When? \_\_\_\_\_  No  
Result:  Negative  Positive

Have you ever had a **tuberculosis blood test**?  
 Yes, When? \_\_\_\_\_  No  
Result:  Negative  Positive