Health Questionnaire

Name: _____ Date:_____

Age:_____ Birthdate_____ Sex: Male / Female Height:_____ Weight: _____

History:

Chief Complaint: (What brings you to the doctor today?)

_____

Do You Have

Regular Bowel movements? Y N # Bowel movements per day____ Formed___ Loose____

Anal or Rectal Bleeding? Y N If yes : Bright red___ Dark red___ With pain___ without pain___
drip in the bowl___ just on the tissue___ or both____

Anal or rectal pain? Y N

Anal or rectal itching ? Y N

Protrusion of rectal tissue to the outside with bowel movements? Y N Abdominal Pain? Y N

Difficulty controlling bowel movements ? Y N

Drug Allergies?: Y N (if yes please list drug and reaction):_____

_____

Medications (Please list all medication, including over the counter meds & vitamins with dosages):

_____

_____

_____

Do you take any anticoagulants? Y N If yes, please select which one and the dosage:

___ Plavix_____ ___Coumadin/Warfarin_____ ___Aspirin_____

Surgical History:

Please list all surgeries/operations: _____

_____

_____

Have you Ever had A?

Recent Barium Enema or Lower GI X-Ray Study? Y N Where_____ When_____

Colonoscopy? Y N Where_____ When_____

Family History:

Has your mother, father, sister, brother, daughter or son had:

Colon/Rectal cancer___ Colon/Rectal polyps___ Ulcerative Colitis or Crohn's disease___

For Women:

How many children have you had?____ How many vaginal deliveries? ___

Social History:

What is your occupation:_____ full time/ part time/ retired.

Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Use of alcohol: How many drinks: _____ daily/weekly/monthly/never

Use of tobacco of any kind: Never /Currently smoking____ (pkgs /day)/ Smokeless/ Previously, but quit:_____

Medical History/Review of Systems:

Constitutional

Fever	y	N
Chills	Y	N
Nightsweats	Y	N
Recent weight loss	Y	N How much_____

Psychiatric

Depression	Y	N
Sleep disorder	Y	N

Cardiovascular

Heart attack	Y	N
Heart failure	Y	N
Heart murmur	Y	N
Mitral valve Prolapse	Y	N
High blood pressure	Y	N
Stroke/TIA	Y	N
Irregular heart beat	Y	N
Aneurysm	Y	N
Poor leg circulation	Y	N
Varicose veins	Y	N
Raynaud's disease	Y	N

Respiratory

Pneumonia	y	N
Asthma	Y	N
Emphysema/ COPD	Y	N
Bronchitis	Y	N
Tuberculosis	Y	N

Genitourinary

Pain with urination	Y	N
Difficulty urinating	Y	N
Frequent urination	Y	N
Urinary incontinence	Y	N

Hematoloy/lymphatic

Anemia	Y	N
Blood Clots	Y	N
Enlarged lymph nodes	Y	N
Leg swelling	Y	N
Lupus	Y	N

Musculoskeletal

Back pain	Y	N
Osteoporosis	Y	N
Arthritis	Y	N
Joint pain	Y	N
Fractures	Y	N location:_____

other ortho problems: _____

Allergies/Immunology

AIDS/HIV	Y	N
Hepatitis	Y	N type A/B /C

Integumentary/Skin/Breast

Skin rashes	Y	N Location:_____
Non-healing sore/ulcer	Y	N Location:_____
Breast lump/discharge	Y	N

Neurological

Dizzy spells	Y	N
Seizure/convulsions	Y	N
Headaches	Y	N
Head injury	Y	N
Multiple Sclerosis	Y	N

Eyes/ENT

Visual changes	Y	N describe_____
glaucoma/cataracts	Y	N
loss of hearing	Y	N
Sinus problems	Y	N
Seasonal Allergies	Y	N

Endocrine

Diabetes Y N type: adult/juvenile

Insulin dependent/non-insulin dependent

Thyroid problems	Y	N hyper/hypo
Gout	Y	N

Renal Disease

Kidney failure	Y	N
Bladder infections	Y	N
Kidney stones	Y	N

History of Cancer

Do you have a personal history of cancer

What type:_____