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CEDAR VALLEY
Gastroenterology
At Allen Digestive Health
CedarValleyGI.com

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Patient Health History

NAME: _____ DATE OF BIRTH: _____ AGE: _____

REFERRED BY: _____ PRIMARY DOCTOR: _____

REASON FOR TODAY'S VISIT: _____ TODAY'S DATE: _____

MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER):

_____

_____

_____

_____

_____

_____

_____

_____

NON-STEROIDAL DRUG USE? ☐ YES ☐ NO
(Ex: Aleve, Ibuprofen, Motrin, etc.)

DO YOU TAKE ASPIRIN? ☐ YES ☐ NO

DO YOU USE HERBAL PRODUCTS? ☐ YES ☐ NO

DO YOU TAKE MULTIVITAMINS? ☐ YES ☐ NO

DO YOU TAKE BLOOD THINNERS? ☐ YES ☐ NO

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY):

☐ HEART DISEASE
☐ DIABETES: _____
☐ LUNG DISEASE / COPD
☐ HIGH BLOOD PRESSURE
☐ KIDNEY DISEASE
☐ CELIAC DISEASE
☐ COLITIS/CROHN'S DISEASE
☐ STROKE
☐ HEPATITIS / LIVER DISEASE
☐ ASTHMA
☐ ARTHRITIS
☐ COLON POLYPS
☐ COLON CANCER
☐ SEIZURES / EPILEPSY
☐ GLAUCOMA
☐ CONGESTIVE HEART FAILURE
☐ THYROID DISEASE
☐ CANCER – TYPE: _____
☐ OTHER: _____

FEMALES – IS THERE ANY CHANCE THAT YOU ARE PREGNANT? ☐ YES ☐ NO

ALLERGIES (CHECK ALL THAT APPLY):

☐ NONE
☐ LATEX
☐ PENICILLIN
☐ SULFA
☐ DEMEROL
☐ VERSED
☐ CODEINE
☐ IVP DYE
☐ ENVIRONMENTAL (ex. dust, mold, pollen)
☐ OTHER: _____

Have you ever had an unusual reaction to a general or local anesthetic? ☐ YES ☐ NO

Explain: _____

Have you ever received a blood or a blood-product transfusion?

☐ YES ☐ NO Year: _____

PREVIOUS SURGERIES / PROCEDURES (CHECK ALL THAT APPLY)

☐ HERNIA
☐ APPENDIX
☐ GALLBLADDER
☐ HYSTERECTOMY
☐ TUBAL LIGATION
☐ HIP REPLACEMENT
☐ HEART BYPASS SURGERY
☐ BACK
☐ TONSILS
☐ BREAST
☐ PACEMAKER IMPLANTED
☐ DEFIBRILLATOR IMPLANTED
☐ KNEE REPLACEMENT
☐ HEART VALVE REPLACED
☐ EGD – DATE: _____
☐ COLONOSCOPY – DATE: _____
☐ COLON, INTESTINAL, STOMACH SURGERY - DATE: _____
☐ OTHER: _____

Over

FAMILY HISTORY (CHECK ALL THAT APPLY):

- ☐ CELIAC DISEASE WHO: _____
- ☐ COLITIS / CROHN'S DISEASE WHO: _____
- ☐ COLON POLYPS WHO: _____
- ☐ COLON CANCER WHO: _____
- ☐ LIVER DISEASE / PROBLEMS WHO: _____
- ☐ CANCER WHO/TYPE: _____
- ☐ HIGH BLOOD PRESSURE WHO: _____
- ☐ KIDNEY DISEASE WHO: _____
- ☐ HEART DISEASE WHO: _____
- ☐ LUNG DISEASE WHO: _____
- ☐ DIABETES WHO: _____
- ☐ STROKE WHO: _____

SOCIAL HISTORY:

MARITAL STATUS ☐ M ☐ S ☐ D ☐ W

CAFFEINE ☐ YES ☐ NO QTY: _____

SMOKE ☐ YES ☐ NO QTY: _____

TATTOOS ☐ YES ☐ NO YEAR: _____

OCCUPATION: _____

ALCOHOL ☐ YES ☐ NO QTY: _____

IV DRUG USE ☐ YES ☐ NO WHEN: _____

Do you feel threatened, abused, neglected or exploited in your home? ☐ YES ☐ NO
(If Yes, refer to EPIC Charting)

REVIEW OF SYMPTOMS – PLEASE CHECK YES OR NO TO ALL QUESTIONS:

CONSTITUTIONAL:

WEIGHT LOSS ☐ YES ☐ NO
WEIGHT GAIN ☐ YES ☐ NO
FEVER ☐ YES ☐ NO
CHILLS ☐ YES ☐ NO

EYES:

REDNESS ☐ YES ☐ NO
DOUBLE OR BLURRED VISION ☐ YES ☐ NO

ENT:

HOARSENESS ☐ YES ☐ NO
TROUBLE SWALLOWING ☐ YES ☐ NO

HEMATOLOGIC/LYMPHATIC:

BRUISING ☐ YES ☐ NO
BLOOD CLOTS ☐ YES ☐ NO
ANEMIA ☐ YES ☐ NO

RESPIRATORY/CARDIOVASCULAR:

EDEMA ☐ YES ☐ NO
SHORTNESS OF BREATH ☐ YES ☐ NO
CHEST PAIN ☐ YES ☐ NO

NEUROLOGICAL:

HEADACHES ☐ YES ☐ NO
DIZZINESS ☐ YES ☐ NO
HISTORY OF FALLS ☐ YES ☐ NO
OTHER: _____

GASTROINTESTINAL:

NAUSEA ☐ YES ☐ NO
VOMITING ☐ YES ☐ NO
ACID REFLUX ☐ YES ☐ NO
HEARTBURN ☐ YES ☐ NO
DIARRHEA ☐ YES ☐ NO
CONSTIPATION ☐ YES ☐ NO
BLOOD IN STOOL ☐ YES ☐ NO
ABDOMINAL PAIN ☐ YES ☐ NO
ABDOMINAL BLOATING ☐ YES ☐ NO

MUSCULOSKELETAL:

BACK PAIN ☐ YES ☐ NO
CHEST PAIN ☐ YES ☐ NO
WEAKNESS ☐ YES ☐ NO
JOINT PAIN/SWELLING ☐ YES ☐ NO

UROLOGY:

BLADDER PROBLEMS ☐ YES ☐ NO
KIDNEY DISEASE ☐ YES ☐ NO

INTEGUMENTARY:

SKIN RASH ☐ YES ☐ NO

PSYCHOLOGICAL:

ANXIETY ☐ YES ☐ NO
DEPRESSION ☐ YES ☐ NO
MEMORY LOSS ☐ YES ☐ NO

PATIENT SIGNATURE: _____ DATE: _____

NURSE SIGNATURE: _____ DATE: _____

PROVIDER SIGNATURE: _____ DATE: _____