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CedarValleyGI.com

CEDAR VALLEY
Digestive Health Center

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

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

ALLERGIES (CHECK ALL THAT APPLY):

☐ NONE ☐ DEMEROL
☐ LATEX ☐ VERSED
☐ PENICILLIN ☐ CODEINE
☐ SULFA ☐ IVP DYE
☐ ENVIRONMENTAL (e.g., 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 ☐ BACK
☐ APPENDIX ☐ TONSILS
☐ GALLBLADDER ☐ BREAST
☐ HYSTERECTOMY ☐ PACEMAKER IMPLANTED
☐ TUBAL LIGATION ☐ DEFIBRILLATOR IMPLANTED
☐ HIP REPLACEMENT ☐ KNEE REPLACEMENT
☐ HEART BYPASS SURGERY ☐ HEART VALVE REPLACED
☐ EGD – DATE: ______________________
☐ COLONOSCOPY – DATE: ______________________
☐ COLON, INTESTINAL, STOMACH SURGERY —
DATE: ______________________
☐ OTHER: ______________________

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: ____________