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

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: _____

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: _____

PATIENT SIGNATURE: _____ DATE: _____

NURSE SIGNATURE: _____ DATE: _____

PROVIDER SIGNATURE: _____ DATE: _____