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UnityPoint Health - Allen Hospital

Digestive Health Center

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):

- | | |
|--|---|
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> DIABETES: _____ | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> LUNG DISEASE / COPD | <input type="checkbox"/> COLON POLYPS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> COLON CANCER |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> SEIZURES / EPILEPSY |
| <input type="checkbox"/> CELIAC DISEASE | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> COLITIS/CROHN'S DISEASE | <input type="checkbox"/> CONGESTIVE HEART FAILURE |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> HEPATITIS / LIVER DISEASE | |
| <input type="checkbox"/> CANCER – TYPE: _____ | |
| <input type="checkbox"/> OTHER: _____ | |

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

ALLERGIES (CHECK ALL THAT APPLY):

- | | |
|---|----------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> DEMEROL |
| <input type="checkbox"/> LATEX | <input type="checkbox"/> VERSED |
| <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> CODEINE |
| <input type="checkbox"/> SULFA | <input type="checkbox"/> IVP DYE |
| <input type="checkbox"/> ENVIRONMENTAL (ex. dust, mold, pollen) | |
| <input type="checkbox"/> 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)

- | | |
|--|--|
| <input type="checkbox"/> HERNIA | <input type="checkbox"/> BACK |
| <input type="checkbox"/> APPENDIX | <input type="checkbox"/> TONSILS |
| <input type="checkbox"/> GALLBLADDER | <input type="checkbox"/> BREAST |
| <input type="checkbox"/> HYSTERECTOMY | <input type="checkbox"/> PACEMAKER IMPLANTED |
| <input type="checkbox"/> TUBAL LIGATION | <input type="checkbox"/> DEFIBRILLATOR IMPLANTED |
| <input type="checkbox"/> HIP REPLACEMENT | <input type="checkbox"/> KNEE REPLACEMENT |
| <input type="checkbox"/> HEART BYPASS SURGERY | <input type="checkbox"/> HEART VALVE REPLACED |
| <input type="checkbox"/> EGD – DATE: _____ | |
| <input type="checkbox"/> COLONOSCOPY – DATE: _____ | |
| <input type="checkbox"/> COLON, INTESTINAL, STOMACH SURGERY -
DATE: _____ | |
| <input type="checkbox"/> 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: _____