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GASTROENTEROLOGY
HEPATOLOGY
INTERNAL MEDICINE
ENDOSCOPY

Patient Health Questionnaire

Name: ____ **Date**: ___________________

Date of Birth: __________________ **Primary Doctor**: _______________________________

Reason for Visit: ____

Have you had recent blood tests or x-rays: ☐Yes ☐No Where: ________________________

Describe the Present Symptoms: ____

____

Past Medical Problems: (circle all that apply):

Hypertension	Atrial Fibrillation	Asthma	Anxiety
Diabetes insulin	Stroke	Rheumatoid arthritis	Depression
Diabetes noninsulin	Hyperlipidemia	COPD	Bipolar
Heart Attack	Arthritis	Heartburn	Hypothyroidism

Other: ____

____

Operations

Reason: Approximate Date:

____ _______________________

____ _______________________

____ _______________________

Past Endoscopy Information

Date: ______________________ Where: ____

Findings: ____

Past Colonoscopy Information

Date: ______________________ Where: ____

Findings: ____

Medications and Dosage (Please also include non-prescription medications)

Name of Drug:	Dosage:	Times per Day:
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________

Medication Allergies: ____

Do you take: ☐Aspirin? ☐Ibuprofen (Motrin, Advil)? ☐Naproxen (Aleve)? Dose: ________

How often? ________________ Do these medications upset your stomach? ☐Yes ☐No

Your Family History

	Age	Deceased?	Significant illnesses and/or cause of death
Mother	___	☐	______________________________
Father	___	☐	______________________________
Brothers	___	☐	______________________________
	___	☐	______________________________
Sisters	___	☐	______________________________
	___	☐	______________________________

Children: Ages, Health Problems: ______________________________________

Other Medical Conditions in Your Immediate Family (circle all that apply):

Diabetes	Colitis	Liver Disease
Cancer	Heart Disease	Other: ___________

Social History

Occupation (or former occupation if retired): _______________________________

Do you smoke? ☐Yes ☐No ☐Former How long? _________ Cigarettes per day: __________

Do you drink alcohol? ☐Yes ☐No ☐Former Type: _________ Drinks per week: ___________

Do you drink coffee? ☐Yes ☐No How many cups per day? ____________________

Do you drink milk or take other milk products? ☐Yes ☐No How much? _______________

General Health Questions (Please **CIRCLE** all that apply)

General Health:

- Unexpected weight loss
- Loss of appetite
- Unusual recent life stresses

Heart:

- Chest pain or angina
- Irregular heart beat
- Heart attack or heart failure
- Heart murmur or valve disease

Lungs:

- Shortness of breath
- Asthma or wheezing
- Emphysema or chronic bronchitis
- Pneumonia

Gastrointestinal and Liver:

- Difficult or painful swallowing
- Heartburn or acid reflux
- Nausea or vomiting
- Abdominal pain
- Vomiting blood
- Gallstones
- Pancreatitis
- Hepatitis (type, if known)
- Abnormal liver tests
- Blood transfusions
- Intravenous drugs/needle exposure
- Frequent episodes of diarrhea
- Intestinal infections or colitis
- Chronic constipation
- Blood with bowel movements
- Black or tarry bowel movements
- History of colon polyps

Urinary/Reproductive:

- Frequent urine infections
- Blood in the urine
- Kidney stones
- Painful or difficult urination
- Women: Hysterectomy (Ovaries?)
- If applicable: date of last menstrual period:______________________

Eyes/Ears/Throat:

- History of glaucoma
- Chronic sore throat
- Ear infections

Skin:

- Rashes or itching
- Jaundice

Nervous System:

- Epilepsy or seizures
- Loss of consciousness
- Recurring headaches or migraine

Muscles/Bones/Joints/Extremities:

- Arthritis
- Phlebitis (Inflammation of veins)
- Ankle swelling
- Joint replacement surgery

Endocrine:

- Diabetes
- Thyroid disease

Psychiatric:

- Nervous breakdown
- Depression
- Thoughts of or attempts at suicide

Blood:

- Excessive bruising or bleeding
- Anemia