HUDSON VALLEY
CENTER FOR DIGESTIVE HEALTH

HEALTH QUESTIONNAIRE

Patient Name: ________________________________Date of Birth:__]__j_Age:_ Date of Visit: ______
Daytime phone: (__) Other Phone (__) _________
Reason for visit? : ______________________________
Primary Physician Name. ______________________________
Primary Physician Phone: ______________________________
What is your present Height: _______Weight: Blood Pressure:________________________

PAST MEDICAL HISTORY (Please list any illnesses or medical problems you have had, and the approximate dates of their occurrence)

PAST SURGICAL HISTORY (Please list all operations you have had and the dates of occurrence)

MEDICATION (Please list **ALL** medications that you are currently taking and their doses. Please include over-the-counter and herbal vitamins, aspirin, fish oil etc.)

Name of Medication Strength (i.e.: mg, ml,units, etc.) Frequency (i.e. once a day, 2x a day, etc.)

ALLERGIES
Do you have any allergies to medications? (NO / YES), please list the drugs and type of reaction below:

SOCIAL HISTORY

Do you currently smoke? ____________________ Packs/Day-:-:-------------------
Have you ever smoked? Year you quit:-------------------
Do you drink alcohol? Drinks/week:------------------
Have you ever used intravenous drugs? How many:-------------------

REVIEW OF SYSTEMS (Do you currently have or had a history of the following? Please check all that apply:

General
Recurrent fever
Significant weight loss
Sweats
Anorexia
Fatigue
Malaise
Sleep disorder

Eye, Ear, & Throat
Cataracts
Glaucoma
Tinnitus
Decrease Hearing
Hoarseness
Nosebleeds

Cardiovascular
Abnormal heart valve
High blood pressure
Heart murmur
Heart attack
Peripheral Edema
High cholesterol
Irregular heartbeat
Pacemaker
Defibrillator

Respiratory
Wheezing
Asthma
Shortness of breath
Productive cough
Sleep apnea/CPAP

Abdominai/GI
Hernia
Peptic Ulcer
Difficulty swallowing
Reflux
Gas/bloating
Jaundice
Vomiting
Vomiting Blood
Constipation
Diarrhea
Abdominal Pain
Indigestion/heartburn
Nausea
Change in bowel habits
Bloody BMs
Black BMs
Fecal incontinence

Urologic / Reproductive
Frequent urination
Difficulty urinating
Blood in the urine
Urinary incontinence
Prostate problems
Urinary hesitancy
Nocturnal urination
Vaginal discharge
Number of pregnancies

Rheumatologlc
Joint pain
Joint swelling
Arthritis
Low back pain
Shoulder pain /hand/wrist
Muscle weakness
Leg pain with exertion

Dermatologic
Rash
Itching
Hives
Skin cancer
Unhealing ulcers

Neurologic/Psychiatric
Fainting or blackouts
Anxiety
Depression
Stroke
Frequent headaches
Paralysis
Tremors
Difficulty walking
Sciatica
Confusion
Memory loss
Seizures

Endocrine
Diabetes
Thyroid problems
Steroid use

Hematologic
Bruising
Bleeding
Blood thinner use

Oncologic
Radiation
Chemotherapy

Other:____

Patient Signature ____Date: ___________

FOR OFFICE USE ONLY:

Pain Scale 0-10 _____Location:________________________Relief_____________________________________
Vital Signs:

T_______________________B/P____________________R.______________________________P____________

I have reviewed the above information with the patient on this date.

RN Signature____Date:_____________

Physician's Signature---------------------------Date: ___________