

Health Questionnaire

Please complete both sides of this form and quickly return it to our office in the self addressed envelope provided.
OR You may also download this form from our website at www.salemgastroenterology.com
We appreciate your timeliness in this matter, as it will help ensure an efficient visit with our physician.

Patient Name: _____ Date of Birth: _____ Reason for visit: _____

Are you **CURRENTLY** experiencing any of the following? **If answer is yes, please mark box with a check**

Gastrointestinal

- Acid Regurgitation
- Belching
- Black Tarry Stools
- Bloating
- Constipation
- Change in Bowel Habits
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Jaundice
- Abdominal Pain
- Nausea
- Poor Appetite
- Rectal Bleeding
- Vomiting
- Spitting Up Blood

Heartburn

- Occurs at least 2-3 times a week.
- History of frequent heartburn at least 5-10 years.

General

- Currently Pregnant
- Fatigue
- Fever
- Unexplained Weight Loss

Neurologic

- Black Out Spells
- Blurred Vision
- Migraines
- Numbness
- Seizures
- Weakness

Musculoskeletal

- Arthritis
- Back Pain
- Muscle Disease
- Neck Pain

Hematologic

- Bleed Tendency
- Easy Bruising

Cardiac

- Chest Pain
- Chest pain occurs with exercise
- Chest pain occurs at rest
- Chest pain is due to heart problems
- Been evaluated for chest pain
- Irregular Heartbeat

Respiratory

- Chronic Cough
- Hoarseness
- Shortness of Breath
- Wheezing
- Using Home O₂
 - as needed
 - night
 - continuous

Genitourinary

- Bloody Urine
- Dark Urine
- Excess Thirst or Urination
- Pain on Urination

ENT

- Frequent Nosebleed
- Hearing Loss
- Loose Teeth

Skin

- Current Skin Rash
- Itching
- Skin Nodule
- Skin Ulcer

Psychosocial

- Alcoholism
- Anxiety
- Depression

Have you been diagnosed with the following? **If answer is yes, please mark box with a check.**

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Failure/Requires Dialysis |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Any Implantable Stimulator | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Frequent Bladder Infection | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Previous Stroke |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Cancer - Colon/Rectal | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cancer - Breast | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Stomach Cancer |
| <input type="checkbox"/> Cancer - Esophageal | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Cancer - Ovarian | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> History of Tuberculosis | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> History of Blood Clots | <input type="checkbox"/> Implantable Defibrillator |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> HIV Exposure / Infection |

List your medications with dosage and frequency below, or you may submit a separate Medication List. Also list any drug allergies and associated reactions below. **If none, please mark none.**

Yes, I give Salem Gastro permission to electronically check my prescription history.

Medication/Dosage/Frequency: None Drug Allergies and Reaction None (EXAMPLE: Protonix 40 mg once daily)

Have you had any of the following tests? Please select a time frame for each test below.

	Never	1-5 yrs ago	6-10 yrs ago	10+ yrs ago
Flex Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper GI X-Ray Series	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Surgical History: Please list the year of your surgery below, OR mark none if no history None

Appendectomy _____ Hysterectomy _____

Colon Resection _____ Liver Transplant _____

Gallbladder _____ Kidney Transplant _____

Heart Bypass _____ Tonsillectomy _____

Heart Valve _____ Ulcer _____

Hernia Repair _____

Other Surgeries or cardiac procedures: _____

Have **you** or any of **your blood relatives** had any of the following? If yes, please list their relation to you .

OR is family history **unknown** due to Adoption Estranged from family No knowledge of my family history

	YES	NO	Relation / Age of Diagnosis	Personal History
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Colon/Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Ovarian/Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Tobacco Never used tobacco

Current use: _____ packs per day

Prior use: Quit _____ months / years ago?

Alcohol Never used alcohol

Current use: _____ drinks per day _____ drinks per week

Prior use: Quit _____ months / years ago? _____ drinks per week

Recreational/Illegal Drugs Never used recreational/illegal drugs

Currently using: _____ How often? _____ Last used: _____

Previously used: _____ When? _____