

Health Questionnaire

Name: _____ Date: _____
Age: _____ Sex: Male / Female Height: _____ Weight: _____

History:

Chief Complaint: (What brings you to the doctor today?)

Do You Have

Regular Bowel movements? Y N # Bowel movements per day ____ Formed ____ Loose ____
Anal or Rectal Bleeding? Y N If yes : Bright red ____ Dark red ____ With pain ____ without pain ____
drip in the bowl ____ just on the tissue ____ or both ____
Anal or rectal pain? Y N
Anal or rectal itching ? Y N
Protrusion of rectal tissue to the outside with bowel movements? Y N Abdominal Pain? Y N
Difficulty controlling bowel movements ? Y N

Drug Allergies?: Y N (if yes please list drug and reaction): _____

Medications (Please list all medication, including over the counter meds): _____

Do you take any anticoagulants? Y N If yes, please select which one and the dosage:
____ Plavix _____ ____ Coumadin/Warfarin _____ ____ Aspirin _____

Surgical History:

Please list all surgeries/operations: _____

Have you Ever had A?

Recent Barium Enema or Lower GI X-Ray Study? Y N Where _____ When _____
Colonoscopy? Y N Where _____ When _____

Family History:

Has your mother, father, sister, brother, daughter or son had:
Colon/Rectal cancer ____ Colon/Rectal polyps ____ Ulcerative Colitis or Crohn's disease ____

For Women:

How many children have you had? ____ How many vaginal deliveries? ____

Social History:

What is your occupation: _____ full time/ part time/ retired.
Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____
Use of alcohol: How many drinks: _____ daily/weekly/monthly/never
Use of tobacco: Never ____ Currently smoking ____ (pkgs per day) Previously, but quit: _____

Medical History/Review of Systems:

Constitutional

Fever Y N
 Chills Y N
 Nightsweats Y N
 Recent weight loss Y N How much _____

Psychiatric

Depression Y N
 Sleep disorder Y N

Cardiovascular

Heart attack Y N
 Heart failure Y N
 Heart murmur Y N
 Mitral valve Prolapse Y N
 High blood pressure Y N
 Stroke/TIA Y N
 Irregular heart beat Y N
 Aneurysm Y N
 Poor leg circulation Y N
 Varicose veins Y N
 Raynaud's disease Y N

Respiratory

Pneumonia Y N
 Asthma Y N
 Emphysema/ COPD Y N
 Bronchitis Y N
 Tuberculosis Y N

Genitourinary

Pain with urination Y N
 Difficulty urinating Y N
 Frequent urination Y N
 Urinary incontinence Y N

Hematology/lymphatic

Anemia Y N
 Blood Clots Y N
 Enlarged lymph nodes Y N
 Leg swelling Y N
 Lupus Y N

Musculoskeletal

Back pain Y N
 Osteoporosis Y N
 Arthritis Y N
 Joint pain Y N
 Fractures Y N location: _____
 other ortho problems: _____

Allergies/Immunology

AIDS/HIV Y N
 Hepatitis Y N type A/B /C

Integumentary/Skin/Breast

Skin rashes Y N Location: _____
 Non-healing sore/ulcer Y N Location: _____
 Breast lump/discharge Y N

Neurological

Dizzy spells Y N
 Seizure/convulsions Y N
 Headaches Y N
 Head injury Y N
 Multiple Sclerosis Y N

Eyes/ENT

Visual changes Y N describe _____
 glaucoma/cataracts Y N
 loss of hearing Y N
 Sinus problems Y N
 Seasonal Allergies Y N

Endocrine

Diabetes Y N type: adult/juvenile
 Insulin dependent/non-insulin dependent
 Thyroid problems Y N hyper/hypo
 Gout Y N

Renal Disease

Kidney failure Y N
 Bladder infections Y N
 Kidney stones Y N

History of Cancer

Do you have a personal history of cancer
 What type: _____

