Windsor Center for Digestive Health
A Division of Allied Digestive Health

PATIENT HEALTH HISTORY

Today's Date:____________________

Name:_________________________________
Gender: ______________________________
Date of Birth: ________________________

History of Present Illness:

Reason For Today's Visit:

____
____
____
____

Pain Location:

____
____

Onset was (gradual, abrupt, etc):

____
____

Symptoms Began:

____

Symptoms Occur:
(after meals, after drinking, at night, etc)

____
____

Pain Last: (constant, 2 hours, etc)

____
____

Pain Is: (sharp, dull, burning, etc)

____
____

Last Bowel Movement:

____
____

Current Treatment To Relieve Symptoms:

____
____
____

Past Medical History:

Please circle if you have had:

1. Blood Transfusion
2. Colonoscopy
3. EGD
4. Flexible Sigmoidoscopy
5. ERCP
6. Mammogram

Surgical & Hospitalizations:

____________________ Year:____________
____________________ Year:____________
____________________ Year:____________
____________________ Year:____________

Prescription Medications:

Name: **Dose:** **Frequency:**

____
____
____
____

Over –The – Counter Medications:

____
____
____
____
____

Medication Allergies:

____
____
____
____
____

Reviews of Systems-- Please check if you have or have had any of the following:

Gastrointestinal:

__Abdominal Pain
__Bloating
__Change in Bowel Habits
__Constipation
__Decreased Appetite
__Diarrhea
__Diverticulitis
__Gas
__Gallbladder Disease
__Gallstones
__Heartburn
__Hemorrhoids
__Hiatal Hernia
__Indigestion
__Inflammatory Bowel Disease
__Jaundice
__Hepatitis
__Nausea/Vomiting
__Pancreatitis
__Previous Colon Polyp/Tumor
__Rectal Bleeding
__Trouble Swallowing
__Ulcer

Respiratory:

__Asthma
__Emphysema
__Chronic Cough
__Coughing up Blood
__History Pulmonary Embolism
__Oxygen Therapy
__Pneumonia
__Shortness of Breath
__Tuberculosis

Cardiovascular:

__Chest Pain
__Heart Attack
__High Blood Pressure
__Heart Murmur
__Irregular/Rapid Heart Beat
__Low Blood Pressure
__Pacemaker /Defibrillator
__Rheumatic Heart Disease
__Swelling of Ankles/Feet
__Valve replacement
__Congestive Heart Failure

Genitourinary:

__Blood in Urine
__Frequent Urination
__Lack of Bladder Control
__Kidney Stones
__Kidney Disease
__Renal Failure
__Urinary Infections

Neurologic:

__Dizziness/Fainting Spells
__Paralysis
__Recurrent Headache
__Seizures/Epilepsy
__Stroke/TIA

Muscles/Joints/Bones:

__Artificial Joints
__Arthritis
__Back or Neck Injury
__Rheumatoid Arthritis
__Swelling/Pain
__Arms __Hips
__Back __Legs
__Feet __Neck
__Hands __Shoulders

Endocrine:

__Cortisone Therapy
__Diabetes
__Dry Mouth
__Excessive Hunger
__Excessive Thirst
__Hormone Therapy
__Parathyroid Problem
__Thyroid Problem/Goiter

Ear/Nose/Throat:

__Bleeding Gums
__Dentures
__Hay Fever
__Hearing Loss
__Hoarseness
__Nose Bleeds
__Sinus Problems
__Sores in Mouth

Skin:

__Hives/Rash
__Itching
__Sores that will not heal

Eyes:

__Dry Eyes
__Glaucoma
__Iritis
__Limited Vision
__Yellow eyes

Lymphatic:

__Abnormal Bleeding
__Anticoagulation Therapy
__Blood Disorder
__Bruise easily
__Phlebitis/Blood Clots

Infectious Disease:

__Hepatitis
__Sexually Transmitted Disease

Mental Health:

__Depression
__Panic Attacks/Anxiety
__Phobias

Constitutional:

__Chills
__Fever
__Forgetfulness
__Loss of Sleep
__Night Sweats
__Recent Weight Loss
__Recent Weight Gain

Caffeine:

____ I do not drink caffeine
__Coffee __#Cups/Day
__Decaf __#Cups/Day
__Tea __#Cups/Day
__Soda __#Cups/Day

Tobacco:

____ I do not smoke
____ I have never smoked
____ I smoke:
___ #Cigarettes/Day
___ # Cigars/Day

Alcohol:

__I never drink alcohol
__I Drink:
__# Beers/Day
__# Shots/Day
__# Mixed Drinks/Day
__# Glasses of Wine/Day
__Other
__I am a binge drinker
__I am an alcoholic
__I am a reformed alcoholic
__I drink socially

NON-Prescription Drugs:

__I do not use drugs
__I use recreational drugs
__I use IV drugs

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PATIENT HEALTH HISTORY

Family Health History:

Health of:	Good	Poor	Deceased; Cause of Death	Age
Father				
Mother				
Brother				
Sister				

Immediate Family History of Disease:

Please circle the answer:

Disease:	Please circle option that applies:		Relationship:
Colon Cancer	Yes	No	
Crohn's Disease	Yes	No	
Diabetes	Yes	No	
Liver Disease	Yes	No	
Pancreatitis	Yes	No	
Sprue	Yes	No	
Ulcers	Yes	No	
Ulcerative Colitis	Yes	No	

I certify that the above information is correct and to the best of my knowledge. I do not hold my physician or any member of their staff responsible for any errors or omissions that I have made in completion of this form.

Patient's Signature

Date