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Health History Questionnaire

Please answer each question as completely as you can.

PATIENT NAME_____ TODAY'S DATE_____

MEDICATION

Please list all medications you are currently taking.

1._____ 2._____ 3._____

4._____ 5._____ 6._____

MEDICAL HISTORY

List all your past and present medical conditions, surgical operations, etc.

1._____ 2._____ 3._____

4._____ 5._____ 6._____

ALLERGIES AND SENSITIVITIES

List all medicines you are allergic or sensitive to.

1._____ 2._____ 3._____

4._____ 5._____ 6._____

FAMILY MEDICAL HISTORY

List all medical conditions that affect other members of your family (especially cancers, such as colon, rectal, pancreatic, etc.)

Father_____

Mother_____

Other_____

HABITS

Do you smoke cigarettes? [ ] yes [ ] no If yes, how many packs per day? _____ For how many years?_____
When did you quit?_____

Do you drink alcohol? [ ] yes [ ] no If yes, how many drinks per day? _____ For how many years?_____
When did you quit?_____

Do you use Cocaine? [ ] yes [ ] no If yes, how much per day? _____For how many years?_____
When did you quit?_____

Do you smoke Marijuana? [ ] yes [ ] no If yes, how much per day? _____ For how many years?_____
When did you quit?_____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Congestive Heart Failure	[ ]	Colitis	[ ]	Stomach Ulcers	[ ]
Kidney Disease	[ ]	Heart Attack	[ ]	Irritable Bowel Syndrome	[ ]
Liver Disease	[ ]	Hemorrhoids	[ ]	Cirrhosis	[ ]
Diverticulitis	[ ]	Colon Cancer	[ ]	Other _____	[ ]

What is the nature of your work? _____ Any exposure to toxic chemicals?_____
Have you had a Colonoscopy? [ ] yes [ ] no If yes, what year? _____ What were the findings? _____
Have you had a Barium Enema? [ ] yes [ ] no If yes, what year? _____ What were the findings? _____
Have you had an Upper GI Series? [ ] yes [ ] no If yes, what year? _____ What were the findings? _____

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