Essex Gastroenterology Associates

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Today's Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**Birthdate:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Referring doctor:	
Current Occupation:	

PERSONAL HEALTH HISTORY

Reason for your visit today:

Please indicate if you are having any *current* problems or symptoms in the following areas:	☐ Eyes	☐ Muscular
	☐ Skin	☐ Joints
	☐ Ears, Nose, Throat	☐ Bones
	☐ Stomach/Digestion	☐ Neurological
	☐ Lungs/Breathing	☐ Allergies
	☐ Heart	☐ Reproductive
	☐ Circulation	☐ Thyroid/Endocrine
	☐ Blood	☐ Psychiatric
	☐ Lymph	☐ Urinary

List any medical problems that other doctors have diagnosed:

Surgeries/Hospitalizations

Year	Reason	Hospital

Please go to page 2

List current medications (include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers):		
Name of Drug	**Strength/Dose**	**Frequency Taken**

Allergies to medications ☐ **No** ☐ **Yes (if yes, indicate below)**	
Name of Drug	**Reaction You Had**

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HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Women Only	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	Are you pregnant?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you or any family member have a history of any of the following:		
Cancer If yes, indicate site:	☐ **Yes**	☐ **No**
Heart Disease (Heart Attack/Heart Failure)	☐ **Yes**	☐ **No**
High Blood Pressure	☐ **Yes**	☐ **No**
Stroke	☐ **Yes**	☐ **No**
Diabetes	☐ **Yes**	☐ **No**
Other:		

PATIENT SIGNATURE:

Date: