Gastroenterology Health History Questionnaire

We ask that you take some time with this questionnaire so we can better help you. If any of the questions are difficult to answer, feel free to discuss with your doctor during your visit.

NAME:	**AGE:**	**SEX:**	**DATE:**
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed			
Occupation:			
Number of children:			

1. **PROBLEMS**: What gastrointestinal problems do you want to talk about when you are seen in the clinic?

2. **ALLERGIES:** Are you allergic to or have you had a "bad reaction" to any medications or other substances? ❑ **NO** ❑ **YES** *If yes, please list the medications:*

3. **CHECK IF YOU TAKE:**
   ❑ Aspirin ❑ Pain or Arthritis pills ❑ Coumadin ❑ Plavix ❑ Ticlid
4. **HOSPITALIZATIONS OR SURGERIES:** (Please list type of illness/operation and year)

5. **VACCINATIONS:** (Include year if known)
   ❑ Hepatitis A ❑ Hepatitis B Year: __________

6. Check whether any of your relatives have had any GI related illness (i.e.: colon polyps, colon cancer, inflammatory bowel disease, ulcerative colitis, Crohn's disease, celiac disease/sprue, cirrhosis or other liver problems).

Relative	✔ if yes	Write in illness
Grandparents		
Father		
Mother		
Siblings		
Children		

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Patient Name:

DOB:

MRN:

Clinic Location: