



PREP ONLY
BRIEF MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME _____ **TODAY'S DATE** _____
PATIENT ADDRESS _____ **DATE OF BIRTH** _____
CITY _____ **STATE** _____ **ZIP CODE** _____
PATIENT TELEPHONE NUMBERS _____ **CELL NUMBER** _____
PRIMARY PHYSICIAN _____
SOCIAL SECURITY NUMBER _____
INURANCE COMPANY NAME _____

PAST MEDICAL HISTORY:

Please circle what applies to you.

Atrial Fibrillation	Heart Attack	Stomach Ulcer
Cancer	Heartburn/Reflux	Stroke
Chronic Lung Disease	Hiatal Hernia	Thyroid Disease
Colon Polyps	High Blood Pressure	Transfusions
Congestive Heart Failure	Inflammatory Bowel Syndrome	Weight Gain
Depression	Irritable Bowel Syndrome	Weight Loss
Diabetes	Jaundice	Other: _____
Diverticulosis	Pacemaker	Other: _____
Emphysema	Pancreatitis	Other: _____

PAST SURGICAL HISTORY:

Please circle what applies to you.

Appendix	Heart	Knee
Back	Heart Valve Replacement	Stomach
Colon	Hip	Other: _____
Gallbladder	Hysterectomy	Other: _____

SIGNS AND SYMPTOMS

Please circle what applies to you.

GASTROINTESTINAL:

Abdominal pain
Belching
Bloating
Blood in stool
Blood on toilet paper
Change in bowel habits
Constipation
Diarrhea
Heartburn
Incontinence of stool
Nausea
Stomach cramps
Throwing up blood
Trouble swallowing
Vomiting

GENERAL: fatigue, weight loss, weight gain, fever, chills

EARS/NOSE/THROAT/MOUTH: hoarseness, sinusitis, oral lesions, drainage, dentures

LUNGS: shortness of breath, cough

HEART: chest pain, irregular heartbeat, ankle swelling

BONES/JOINTS: joint pain, muscle weakness, back pain

URINARY: blood in urine, painful or difficult urination

NEUROLOGIC: depression, headaches, tremors, migraines

HEMALOGIC: easy bruising, bleeding, blood transfusions

SKIN: yellowing, ulcers, infections, hives

OTHER: _____

(turn over-next page)

SOCIAL HISTORY:

Please circle what applies to you.

Status	Married	Single	Widowed
Children	None	State how many _____	
Occupation	_____		
If retired, past occupation	_____		
Do you drink alcohol?	No	Yes	
If yes, how many ounces per day:	_____	Favorite drink: _____	
Do you use tobacco?	No	Yes	
If no, did you ever smoke?	No	Yes	When did you quit? _____

FAMILY HISTORY:

Please circle what applies to you.

<u>Disease</u>	<u>State Relationship</u>
Celiac Disease	_____
Colon Cancer	_____
Colon Polyps	_____
Crohn's Disease	_____
Liver Disease	_____
Pancreatic Disease	_____
Stomach Ulcers	_____
Ulcerative Colitis	_____

MEDICATIONS:

Please list the current prescription medications that you take.

<u>Name of Medication</u>	<u>Amount Per Day</u>	<u>When Started Taking (approx)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over the counter preparations that you are currently taking (including vitamins, herbals):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES TO MEDICATIONS:

Do you have allergies?	No	Yes
If Yes, what are they?	_____	