

# DIGESTIVE HEALTH SPECIALISTS—AZ HEALTH HISTORY FORM

**PLEASE PRINT CLEARLY**

*Bring this form to your appointment:* Date: \_\_\_\_\_ Time: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ M F

Referring Doctor: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_ Previous Doctor: \_\_\_\_\_

Preferred Pharmacy Location: \_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_

Reason for Visit & Problems, if any: \_\_\_\_\_

**MEDICATIONS (Including over the counter medications)**  
Please list all medications and/or bring a list with you.

NO MEDICATIONS

Medication Name	Strength of Each Dose	Number of Doses At A Time	How Many Times A day

**ALLERGIES: Do you have any allergies? Please list medication and food allergies and reaction.**

NO KNOWN ALLERGIES Do you have a Latex Allergy?  YES  NO

	Medication	Reaction		Medication	Reaction
1			4		
2			5		
3			6		

**Do you use any of the following?**

- |  |                     |  |
|--|---------------------|--|
| ___ Aspirin, Anacin or Bufferin        | ___ Laxatives       | ___ Vitamins                                   |
| ___ Ibuprofen (Advil, Motrin)          | ___ Stool Softeners | ___ Birth Control Pills                        |
| ___ Tylenol                            | ___ Iron            | ___ Blood Thinners (Coumadin, Plavix, Heparin) |
| ___ Hormones: _____                    |                     |  |
| ___ Other arthritis medications: _____ |                     |  |
| ___ Herbal Supplements: _____          |                     |  |

**SURGICAL HISTORY:** NO SURGICAL HISTORY

Appendectomy	____ MO/ ____ YR	Hysterectomy: <i>(please circle)</i> Vaginal / Abdominal	____ MO/ ____ YR
Gall Bladder	____ MO/ ____ YR	Abortion	____ MO/ ____ YR
Open Heart	____ MO/ ____ YR	Births: <i>(please circle)</i> C-Section / Vaginal	____ MO/ ____ YR
Heart Valve	____ MO/ ____ YR	Other:	____ MO/ ____ YR
Hernia Repair	____ MO/ ____ YR	Other:	____ MO/ ____ YR

**PROCEDURE HISTORY:** NO PROCEDURE TO DATE

Procedure	Date	Results
Colonoscopy		
Barium Enema		
EGD		
Sigmoidoscopy		
Upper GI		

**PROBLEM LIST / MEDICAL HISTORY: PLEASE CHECK ALL THAT PERTAIN TO YOURSELF**

<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Stroke / CVA
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Duodenal Ulcer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gastric Ulcer	<input type="checkbox"/> Lung Disease	*Cancer - please list type:
<input type="checkbox"/> Barrett's	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Neurological Disease	_____
<input type="checkbox"/> Cancer*	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Pancreatitis	_____
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> NO PROBLEMS
<input type="checkbox"/> Crohn's	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Reflux (GERD)	
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Valve Replacement	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sleep Apnea	

**MEDICAL HISTORY MISCELLANEOUS QUESTIONS:**

Are you taking ORAL STEROIDS at this time? If yes, for how long? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you had a VASCULAR GRAFT placed in the last year, ENDOCARDITIS, PROSTHETIC VALVE OR SYSTEMIC PULMONARY SHUNT? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever received a BLOOD TRANSFUSION? If yes, please GIVE DATE. _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever been HOSPITALIZED? If yes, please give date & reason: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you PREGNANT? If yes, give expected delivery date: _____	<input type="checkbox"/> YES <input type="checkbox"/> UNCERTAIN	<input type="checkbox"/> NO

**SOCIAL HISTORY:**

**Occupation:** \_\_\_\_\_ **Marital Status:** M S D W Sep

**Alcohol**       None     Occasional     Moderately     Heavy     Socially     Weekends  
                     \_\_\_\_\_ Drinks per week     Beer             Wine         Liquor         Recovering Alcoholic

**Tobacco**      Do you use tobacco?             Yes             No            ( \_\_\_\_\_ Quit \_\_\_\_\_ Year)  
                      Cigarettes                     Chew             Pipe             Cigars            (amount per day \_\_\_\_\_)

**Drugs**            Do you currently use recreational or street drugs?     Yes             No  
                     If yes, please list type of drug: \_\_\_\_\_ How often: \_\_\_\_\_  
                     Have you ever given yourself drugs with a needle?     Yes             No

**Exercise**         No Exercise                     Mild Exercise     Occasional Vigorous Exercise  
                      Regular Vigorous Exercise

**Diet**             Are you on a special diet?         Yes             No  
                     If yes, are you on a physician prescribed medical diet?     Yes             No  
                     Describe: \_\_\_\_\_

**Caffeine**         None     Coffee         Tea             Cola            # of Cups/Cans per day? \_\_\_\_\_

**FAMILY HISTORY:**

Family history unknown - Adopted

	Significant Health Problems	Living or Deceased	Age
Mother			
Father			
Brothers			
Sisters			
Daughter			
Son			

Has any member in your family had any of the following? If so, please list who and if mother's or father's side.

<input type="checkbox"/> Cirrhosis		<input type="checkbox"/> Gallstones	
<input type="checkbox"/> Colon Cancer		<input type="checkbox"/> Gastric Cancer	
<input type="checkbox"/> Colon Polyps		<input type="checkbox"/> Liver disease	
<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Pancreatic Cancer	
<input type="checkbox"/> Duodenal Ulcer		<input type="checkbox"/> Pancreatitis:	
<input type="checkbox"/> Esophageal Cancer		<input type="checkbox"/> Ulcerative Colitis:	
<input type="checkbox"/> Gastric Ulcer		<input type="checkbox"/> Other:	

**Please take a moment and check any symptoms that you may be experiencing.**

Thank you for your time. This information will assist us to help you. Remember to bring this form with you to your appointment. Please feel free to call if you have any questions, 480-563-5757

**CARDIOVASCULAR**

- Abnormal swelling of the legs
- Chest Pain
- Chest Pressure
- Irregular Heartbeat
- Rapid Heartbeat
- Shortness of Breath

**CONSTITUTIONAL**

- Chills
- Chronic Fatigue
- Fever
- Sweats
- Weight Gain \_\_\_\_\_ lbs.
- Weight Loss \_\_\_\_\_ lbs.

**ENDOCRINOLOGY**

- Excessive Thirst
- Excessive Urination
- Intolerance to Cold
- Intolerance to Heat

**ENT**

- Hoarseness
- Loss of Hearing
- Nose Bleeds
- Ringing in Ears
- Sinus Problems
- Sore Throat

**EYES**

- Blurred Vision
- Cataracts
- Double Vision
- Glaucoma

**GASTROINTESTINAL**

- Abdominal Pain
- Black Tarry Stools
- Bloating
- Blood in Stools
- Constipation
- Cramps
- Decreased Appetite
- Diarrhea
- Difficulty Swallowing
- Gas
- Heartburn
- Leakage of Stool
- Milk/Dairy Intolerance
- Mucus in Stool
- Nausea
- Rectal Pain
- Vomiting
- Vomiting Blood

**GENITOURINARY**

- Blood in Urine
- High Urine Output
- Kidney Stones
- Low Urine Output
- Painful Urination
- Pus/Discharge in Urine

**HEMATOLOGY/LYMPHATIC**

- Abnormal Bleeding
- Anemia
- Easy Bruising
- Enlarged/Swollen Glands
- Increased Bleeding
- Increased Bruising
- Nosebleeds

**MUSCULOSKELETAL**

- Back Pain
- Joint Pain
- Muscle Weakness
- Neck Pain
- Stiffness in Back
- Stiffness in Joints
- Stiffness in Neck
- Swelling in Joints

**NEUROLOGY**

- Dizziness
- Equilibrium Problems
- Headaches
- Loss of Consciousness
- Memory Loss
- Migraines
- Numbness
- Seizures
- Tingling

**PSYCHIATRY**

- Anxiety
- Death of a Loved One
- Depression
- Job Change
- Panic Attacks
- Retirements

**RESPIRATORY**

- Abnormal Swelling of the Legs and Feet
- Asthma
- Bronchitis
- Coughing Up Blood
- Coughing Up Sputum
- Exposure to Tuberculosis
- Persistent Cough
- Pneumonia
- Shortness of Breath
- Wheezing

**SKIN**

- Abnormal Pigmented Areas
- Allergic Reaction
- Breast Biopsy
- Breast Mass
- Breast Tenderness
- Rash

NOT EXPERIENCING  
ANY OF ABOVE LISTED  
SYMPTOMS

\_\_\_\_\_  
**Signature**