CAPITAL CITY GASTROENTEROLOGY, P.C.

Patient Health Questionnaire

Patient Name _____ Today's Date_____

Date of Birth _____ Age _____ Male___ Female ___

Marital Status: Single ___ Married___ Divorced___ Widowed_____

Occupation_____

Primary Physician_____ Referring Physician_____

Reason for today's visit_____

Medications and doses (List all, including over the counter, herbs and vitamins)

_____ _____

_____ _____

_____ _____

_____ _____

Allergies _____

Hospitalizations/Surgeries_____

Social History:

Smoking: Never _____ Quit _____Packs/Day_____ _____

Alcohol: Never_____ Rarely_____ Daily_____ _____

History of recreational or IV drug use? _____

Family History: (If no longer living, please note age and cause of death)

Father_____ Mother_____ Sister/Brother_____ Children_____

Gallstones _____ Relation_____
Colon Polyps_____ Relation_____
Colon Cancer_____ Relation_____
Pancreatitis_____ Relation_____
Liver Disease_____ Relation_____
Crohns Disease_____ Relation_____
Ulcerative Colitis_____ Relation_____
Other Cancer _____ Relation_____
Other Illness_____ Relation_____

REVIEW OF SYSTEMS
(Check all that apply to patient's health history)

GENERAL:

____ Chronic fatigue ____Bruise/easily/bleed too long ____Fever
____ Weight Loss ____Weight Gain ____Anemia
____ Thyroid disease ____Cancer (type :_____)
____ Sleep Apnea ____Diabetes (type:_____ when diagnosed_____)

EYES, EARS, NOSE & THROAT:

____ Ringing in ears ____Sinus Trouble ____Hearing Loss
____ Ear infections ____Hoarseness ____Dizzy Spells
____ Eye infection ____Poor vision ____Cataracts
____ Glaucoma

LUNGS

____ Pneumonia ____Bronchitis ____Blood in sputum
____ Asthma ____Cough, chronic ____History of tuberculosis
____ Shortness of breath

HEART

____ Chest Pain ____Palpitations ____History of heart attack
____ High blood pressure ____Ankle swelling ____Heart valve problems
____ Irregular heart beat ____Blood Clots

SKIN

____ Rashes ____Allergic Reactions ____Hives
____ Growths ____Skin Cancer

URINARY

____ Urine infections ____Painful urination ____Kidney failure
____ Kidney stones ____Decrease in urine force or flow ____Dialysis
____ Blood in urine ____Urination at night

BONES & JOINTS

____ Arthritis/rheumatism ____Weak Bones ____Back pain
____ Swollen joints

NEUROLOGIC/PSYCHIATRIC:

____ Stroke ____Depression ____Tremor/hands shaking
____ Nervousness ____Numbness or tingling ____Problems with sleeping
____ Headaches (frequent) ____Memory loss ____Anxiety
____ Migraines ____Seizures ____Panic attacks

GASTROINTESTINAL

____ Diarrhea ____Constipation ____Pancreatitis
____ Heartburn ____Stomach Pain ____Crohn's Disease
____ Black Stools ____Change in bowel movements ____Poor appetite
____ Nausea ____Vomiting ____Ulcerative colitis
____ Blood in Stool ____Bloating ____Colon polyps
____ Liver disease/Hepatitis ____Gas ____Trouble swallowing
____ IBS (Irritable Bowel Syndrome

Any additional information you feel is important: _____

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