McLaren MEDICAL GROUP

McLaren Digestive Health:
Health History Questionnaire

Name: ________________________ DOB: __________ Age: __________

☐ Male ☐ Female Reason for Visit: ________________________

Primary Care Provider: ________________ Referring Provider: ________________

MEDICATION LIST: Please see back

SURGERIES: Please see back

ALLERGIES:

____

____

____

____

SOCIAL HISTORY:

Smoke Cigarettes Ever? Y / N
Packs per day? _____
For how long? ____
When did you quit? ______

Other tobacco/nicotine? ________________

Marijuana? Y / N
Prescribed? __________
Recreational? __________

Recreation drugs? ____________________

Consumes alcohol? Y / N
Amount? _____
Frequency ____
When did you quit? ____

Drinks caffeine? Y / N
Cups per day? ________

Consume Pop/Soda? Y / N
Cups per day ______

GASTROENTEROLOGICAL:

__ Abdominal pain
__ Difficulty Swallowing
__ Reflux __ Heartburn
__ Nausea __ Vomiting
__ Loss of Appetite
__ Gas __ Belching __ Bloating
__ Diarrhea __ Constipation
__ Black stool __ Bloody stool
__ Fecal Incontinence
__ Mucous in stool
__ Hemorrhoids
__ Rectal pain __ Rectal itch
__ Rectal bleeding

REVIEW OF SYSTEMS:

GENERAL SYMPTOMS:
__ Fever __ Chills __ Night Sweats
__ Fatigue __ Trouble Sleeping
__ Weight Loss > 5lbs
__ Weight Gain > 5lbs

NEUROLOGIC:
__ Chronic Headaches __ Migraines
__ Dizziness __ Fainting __ Weakness
__ Numbness __ Black outs

EENT:
__ Recent change in vision
__ Mouth pain __ Sore throat
__ Hearing difficulty
__ Hearing Aides ______________

CARDIOVASCULAR:
__ Chest Pain __ Ankle Swelling
__ Murmur __ Palpitations
__ Arrhythmia __ Easy Bleeding
__ Bruising __Circulatory Problems
__ Pacemaker / Defibrillator

PULMONARY:
__ Breathing Problems
__ Short of breath __ Cough
__ Mucus changes
__ Sleep apnea __ CPAP

GENITOURINARY:
__ Dialysis ____________________
__ Sexually transmitted disease

ENDOCRINE:
__ Excessive thirst __ Change in diet
__ Change in appetite __ Change in activity

SKIN:
__ Rash __Sores __ Swollen glands
__ Change in color of skin __ Jaundice

MUSCULOSKELETAL:
__ Joint pain __ Arthritis __ Limited motion
__ Back pain __ Neck pain
__ Limb pain / swelling
__ Protheses ____________________

ANESTHESIA / SURGICAL:
__ Blood transfusion reaction
__ History of anesthesia problems

IMMUNIZATIONS:
Have you been vaccinated for:
__ Hepatitis A __ Hepatitis B

Have you been tested for tuberculosis? ___

PAST HISTORY (check all that apply)

__ Seizure __ Stroke CVA/TIA
__ Head Injury __ Heart Attack
__ Congestive Heart Failure
__ High Blood Pressure/Hypertension
__ Bleeding __ Clotting
__ Anemia __ High Cholesterol
__ Asthma __ Emphysema
__ Kidney Disease __ Kidney Stone
__ Diabetes __ Hypoglycemia
__Thyroid Problems
__ Arthritis __ Limited Motion
__ Chronic Pain
__ HIV __ AIDS __ MRSA
__ Anxiety / Depression
__ Suicide Attempt __ Sexual Assault
__ Alcoholism
__ Cancer / Tumor __ Chemo / Radiation
__ Hiatal Hernia __ Ulcer
__ Liver Disease __ Hepatitis C
__ Crohn's Disease __ Ulcerative Colitis
__ Colitis
__ Irritable Bowel Syndrome (IBS)
__ Celiac Disease __ Lactose Intolerance

Have you taken antibiotics in the past year?
____

FAMILY HISTORY:

	Mom	Dad	Sis	Bro	Son	Dau
Crohn's/Colitis						
Colon Cancer						
Colon Polyps						
Heart Disease						
Stroke						
Diabetes						
Hypertension						
Other Cancer						

CONTINUED ON BACK

MEDICATIONS / SUPPLEMENTS / VITAMINS:

Please include strength and frequency.

(including all over-the-counter)

ENDOSCOPY PROCEDURES:

Have you ever had a colonoscopy or flexible sigmoidoscopy?

When? ____________________

Where? ____________________

Have you had an Upper Endoscopy / EGD:

When? ____________________

Where? ____________________

HOSPITALIZATIONS AND SURGERIES:

DIET & EXERCISE:

Do you follow a special diet?

Gluten-free: ____ Lactose-free: ____

Diabetic: ____ Heart healthy: ____

Vegetarian: ____ Vegan: ____

FODMAP: ____

Other: ____________

How many meals / snacks do you eat each day?

Meals: ____ Snacks: ____

Number of servings you eat of these each day:

Fruits: ____ Vegetables: ____

How many times a week do you eat desserts or sweets? ____

How much water do you drink daily? ____

What other types of beverages do you drink?

Juice: ____ Sports drinks: ____

Tea: ____ Milk: ____

How many times a week do you exercise? ____

What is your daily activity level:

Sedentary: ____ Low Activity: ____

Moderately Active: ____ Very Active: ____

Recent Testing: ____

Reviewed by Provider:

Provider Signature: ____________________ Date: ______/______/_________ Time: ______________