

DOWNRIVER GASTROENTEROLOGY, P.C.
FRANK SINGH, D.O.

HEALTH HISTORY

Name: _____
 Primary Care Doctor: _____

Date of Birth: _____
 Age: _____

REVIEW OF SYSTEMS

Have you or the patient ever been diagnosed with any of the following? If yes, please CHECK ALL THAT APPLY. Is your family physician aware of any of these symptoms/illnesses that you have checked below? Yes No

GASTROINTESTINAL		CARDIAC		NEUROLOGIC		EAR, NOSE & THROAT	
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nose Bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rectal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Deafness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change in Bowel Habits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Previous Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	PSYCHOSOCIAL	
Weight Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	RESPIRATORY		MUSCULOSKELETAL			
Polyps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irritable Bowel	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcerative Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	BREAST	
Trouble Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Nausea or Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tracheotomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	SKIN		Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	GENITOURINARY				Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruises	<input type="checkbox"/> Yes <input type="checkbox"/> No		
HEPATIC		Frequent Urine Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	OPHTHALMIC			
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	ENDOCRINE/METABOLIC		Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Are you 65 or older? Yes _____ No _____

If yes, do you have an advanced care plan? Yes _____ No _____

Please explain any YES answers in detail in the description box provided.

Have you ever had surgery or been hospitalized?	<input type="checkbox"/> Yes	Surgeries	Dates	Hospitalizations w/o Surgery	Date		
	<input type="checkbox"/> No						
Have you had any problems with anesthesia?	<input type="checkbox"/> Yes						
	<input type="checkbox"/> No						
Do you use any Tobacco products? <input type="checkbox"/> Quit Smoking Date ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	Packs/Day/#Years	Week	Month			
Do you use any Alcohol products? <input type="checkbox"/> Quit Drinking Date ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drinks/Day	Week	Month			
Are you or have you ever used recreational / illicit drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what kind? For how long?					
Are you currently taking any medications or drugs (including over-the-counter, prescription, birth control pills)?	<input type="checkbox"/> Yes	Medication	Strength	Times	Medication	Strength	Times
	<input type="checkbox"/> No						
Do you have any allergies (including environmental, medication, food, and reaction to previous blood transfusions)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:					
Please list your current/past medical history.							

FAMILY HISTORY: Please indicate if your parents, brothers, sisters and/or children have had any of the following conditions.

Condition	Relation to Patient	Condition	Relation to Patient	Condition	Relation to Patient
Colon/Rectal Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No		Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No		Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Stomach Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No		Ulcerative Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No		Crohn's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
Breast Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No		Ovarian Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No		Bleeding Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Guardian

Date

Reviewed by Provider