DOWNRIVER GASTROENTEROLOGY, P.C.

FRANK SINGH, D.O.

HEALTH HISTORY

Name: _____ Date of Birth: _____

Primary Care Doctor: _____ 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	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	Loose Teeth	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Weakness	☐ Yes ☐ No	Nose Bleeds	☐ Yes ☐ No
Rectal Bleeding	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Deafness	☐ Yes ☐ No
Change in Bowel Habits	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No	Previous Stroke	☐ Yes ☐ No	PSYCHOSOCIAL	
Weight Loss	☐ Yes ☐ No	RESPIRATORY		MUSCULOSKELETAL		Alcoholism	☐ Yes ☐ No
Polyps	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Muscle Disease	☐ Yes ☐ No	Substance Abuse	☐ Yes ☐ No
Irritable Bowel	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Crohn's Disease	☐ Yes ☐ No	Bronchitis	☐ Yes ☐ No	Neck pain	☐ Yes ☐ No	Anxiety Disorders	☐ Yes ☐ No
Ulcerative Colitis	☐ Yes ☐ No	Chronic Cough	☐ Yes ☐ No	Back Pain	☐ Yes ☐ No	BREAST	
Trouble Swallowing	☐ Yes ☐ No	Hoarseness	☐ Yes ☐ No	Blood Disorders	☐ Yes ☐ No	Lumps	☐ Yes ☐ No
Nausea or Vomiting	☐ Yes ☐ No	Tracheotomy	☐ Yes ☐ No	SKIN		Cancer	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No	GENITOURINARY		Rash	☐ Yes ☐ No	Please list below: Any Symptoms/Diseases you have that are not listed?	
Abdominal Pain	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Bruises	☐ Yes ☐ No		
HEPATIC		Frequent Urine Infection	☐ Yes ☐ No	OPHTHALMIC			
Liver Disease	☐ Yes ☐ No	ENDOCRINE/METABOLIC		Cataracts	☐ Yes ☐ No		
Hepatitis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No		
Pancreatitis	☐ Yes ☐ No	Thyroid Disorders	☐ Yes ☐ No	Blindness	☐ Yes ☐ No		

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

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

Date of your last Influenzia vaccine?		
Date of your last Pneomonia vaccine?		
Date of your last Mammogram?		
Are you 65 years old or older? (Circle One)	**Yes**	**No**
If Yes, do youhave an Advanced Care Plan? (Circle One)	**Yes**	**No**

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 ☐ Yes ☐ No		Kidney Problems ☐ Yes ☐ No		Heart Disease ☐ Yes ☐ No	
Stomach Cancer ☐ Yes ☐ No		Ulcerative Colitis ☐ Yes ☐ No		Crohn's Disease ☐ Yes ☐ No	
Breast Cancer ☐ Yes ☐ No		Ovarian Cancer ☐ Yes ☐ No		Bleeding Problems ☐ Yes ☐ 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 ommisions that I may have made in the completion of this form.

Signature of Patient or Guardian _____ Date _____ Reviewed by Provider _____