NORTHERN
Gastroenterology
a department of Northern Regional Hospital

Patient Name:_____ Date: _____

Patient's Personal Health History

Date of Birth: _____

FAMILY HISTORY

	If Living		If Deceased	
	Age	**Health**	**Age at Death**	**Cause**
Father				
Mother				
Brothers/Sisters (Circle Sex)				
M F				
M F				
M F				
M F				
M F				
Husband/Wife				
Sons/Daughters (Circle Sex)				
M F				
M F				
M F				
M F				
M F				

Check if any **blood relative** has had any of the following, and enter relationship to you.

	Yes	No	Relation		Yes	No	Relation
Colon cancer				Diabetes			
Other cancer				Tuberuclosis			
Colon polyps				Heart problems			
Colitis				Emphysema			
Easy bleeding				Stomach ulcer			
Cirrhosis				Kidney disease			
Liver disease				Depression			

Check if **YOU** have had any of the following, and enter approximate date of onset.

	Yes	No	Relation		Yes	No	Relation
Colon cancer				Diabetes			
Other cancer				Tuberuclosis			
Colon polyps				Heart problems			
Colitis				Emphysema			
Easy bleeding				Stomach ulcer			
Cirrhosis				Kidney disease			
Liver disease				Depression			
Hepatitis				High blood pressure			
Seizures				Stroke			

Have you ever had a blood transfusion? Yes_____ No_____

When?_____Why? _____

General Health Review (Check items that apply to you.)

General Health

No Problems _____

Recent weight gain _____

Recent weight loss _____

Unusual tiredness _____

Skin

No Problems _____

Change in skin color _____

Change in moles _____

Excessive sweating _____

Sores that don't heal _____

Eyes

No Problems _____

Change in vision _____

Pain in eyes _____

Transient blindness _____

Glaucoma _____

Ears, Nose, Throat

No Problems _____

Trouble hearing _____

frequent dizziness ____

Nasal stuffiness _____

frequent nosebleeds _____

bleeding gums _____

Hoarseness _____

Mouth sores _____

Swollen glands _____

Respiratory

No Problems _____

Coughing of blood _____

Persistent cough _____

Shortness of breath _____

Frequent chest colds _____

wheezing _____

Musculoskeletal

No Problems _____

Trouble walking _____

Back pain _____

Severe joint pains _____

Gynecologic

No Problems/Not Applicable _____

Post−menopausal_____

Irregular periods _____

Use birth control _____

Hormone therapy _____

Breast lumps _____

Nipple discharge _____

Heart

No Problems _____

Chest pain or short of breath _____

walking up hill _____

Lying down _____

Climbing stairs _____

Gastrointestinal

No Problems _____

Blood in stools _____

Black or tarry stool _____

Trouble swallowing _____

Frequent heartburn _____

frequent belching _____

abdominal bloating _____

Intestinal gas _____

Frequent nausea _____

Frequent vomiting _____

Appetite loss _____

frequent diarrhea _____

frequent constipation _____

Laxative use _____

Genitourinary

No Problems _____

Frequent urination _____

Night urination _____

Blood in urine _____

Poor bladder control _____

frequent urinary infections _

Have you ever had a colonoscopy?

Yes _____ No _____

Where? _____

When? _____

By which physician? _____

Have you had a pneumococcal vaccine ("pneumonia shot")?

Yes_____(if so, what year?_____) No _____

If female, when was your last mammogram? _____

Allergies to Medicines or Latex? Please list below:

MEDICATIONS: (All prescription and non−prescription)	Operations:
	Other hospitalizations and approximate year:
	Diagnostic X−rays: (Give approximate dates)
	Personal Habits:
	Do you smoke cigarettes? No Yes #Packs/day
	#Years of smoking?
	If a former smoker, # years since you quit: _____
	Do you drink alcohol? No Yes
	Beer? Bottles/day
	Wine? Glasses/day
	Liquor? oz./day _____

Marital/Family/Living Situation	Yes	No
Have you been married more than one time?		
Have you recently been married, divorced or separated?		
Are there problems with your marriage?		
Do you have any problems with sex?		
Is your present home life causing unhappiness?		
Have there been any deaths among family or close friends in the last year or two?		
Does anyone in your family have a serious illness or disability?		
Does anyone in your family have drug or alcohol problems?		
Do you have any serious problems with your children?		
Have you ever, or are you currently experiencing physical abuse or domestic violence?		
Are you afraid in your current living situation?		
Are you an organ donor?		
General Information:		
Are there any cultural, religious or emotional factors that make it more difficult for you to understand healthcare information?		
If so, please describe:		
What is your preferred language for discussing healthcare information? English_____Spanish_____Other _____		
Do you have advance directives? (Living Will, Health Care Power of Attorney)		