COLORADO GASTROENTEROLOGY

PROFESSIONAL LLC

CONSULTANTS IN LIVER AND DIGESTIVE DISEASES

Patient Health Questionnaire

Today's Date ___/___/___

Patient Name: _____ **Primary Doctor:** _____

Person completing the form, if not patient: _____

Date of Birth: ___/___/___ Personal Information: __Married __Divorced __Single __Separated __Widowed

Occupation: _____ How long? _____

Medical Conditions:

_____

_____

_____

_____

_____

Medications: (List all, including birth control, over the counter medications, herbs and vitamins)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Hospitalizations/Surgeries: Patient Only

_____

_____

Allergies: (List all medications and type of reaction)

_____ _____

_____ _____

Social History:

Smoking ___ Packs/day _____ Number of years smoking ____ If you quit, when? _____

Alcohol use ___ Drinks/day _____ If you quit, when? _____

Cocaine, marijuana, etc. use _____ Recent travel: When _____ Where_____

HEALTH OF FAMILY: (If no longer living, please note age and cause of death)

Father _____ Mother _____ Sister/Brother _____ Children _____

FAMILY HISTORY: (Indicate any known illnesses of family members and relationship to the patient)

Gallstones _____ Relation _____

Colon Polyps _____ Relation _____

Colon Cancer _____ Relation _____

Pancreatitis _____ Relation_____

Liver Disease _____ Relation _____

Other cancer _____ Relation _____

Other illness _____ Relation _____

Patient Name: _____ **Date of Birth:** _____

REVIEW OF SYSTEMS: Check all that apply to the patient's health history

GENERAL:

__Chronic fatigue
__Weight loss (amount____, time____)
__Weight gain (amount____, time____)
__Fever
__Anemia
__Bruise easily/bleed too long
__Cancer (type:_____)
__Diabetes (diagnosed when? _____)
__Thyroid disease
__Less interest in doing things

EYES, EARS, NOSE & THROAT:

__Ringing in ears
__Ear infections
__Dizzy Spells
__Poor vision
__Glaucoma
__Sinus trouble
__Hoarseness
__Eye infections
__Cataracts

LUNGS:

__Pneumonia
__Asthma
__Shortness of breath
__Bronchitis
__Cough

HEART:

__Chest pain
__High blood pressure
__Irregular heart beat
__Palpitations
__Ankle swelling
__Blood clots

SKIN:

__Rashes
__Hives
__Allergic reactions
__Growths

URINARY:

__Urine infections
__Kidney stones
__Blood in urine
__Painful urination
__Decrease in urine force or flow
__Urination at night

BONES AND JONES:

__Arthritis/rheumatism
__Back pain
__Weak bones
__Swollen joints

NEUROLOGIC/PSYCHIATRIC:

__Stroke
__Tremor/hands shaking
__Numbness or tingling
__Headaches (frequent)
__Migraines
__Seizures
__Depression
__Nervousness
__Problems with sleeping
__Memory loss
__Anxiety
__Panic attacks

GASTROINTESTINAL:

__Diarrhea
__Heartburn
__Black stools
__Nausea
__Blood in stool
__Liver disease
__Trouble swallowing
__Constipation
__Stomach pain
__Poor appetite
__Vomiting
__Bloating
__Gas

Any additional information you feel is important:

_____

For office use only:

DATE REVIEWED AND UPDATED: (Physician to sign and date)

_____ _____ _____