UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Gastroenterology **Health History Questionnaire - New Patient -Gastroenterology**	MRN: NAME: BIRTHDATE: CSN:

Date of appointment _____/_____/_____ (mm/dd/yyyy)

Please fill this form out as completely as possible and bring this to your appointment.

Past Medical History (please check any medical problems that you have had in the past):

☐Anemia	☐Depression	☐Kidney stones
☐Anticoagulation therapy	☐Diabetes mellitus	☐Liver disease
☐Anxiety	☐Fatty liver	☐Myocardial infarction (heart attack)
☐Arthritis	☐Fibromyalgia	☐Osteoporosis
☐Cancer	☐GERD (heartburn)	☐Pancreatitis
☐Cataracts	☐Heart disease or pacemaker	☐Primary biliary cirrhosis
☐Chronic lung disease	☐Hepatitis B	☐Primary sclerosing cholangitis
☐Cirrhosis	☐Hepatitis C	☐Rashes/ skin problem
☐Colon polyps	☐Hyperlipidemia (high cholesterol)	☐Renal insufficiency
☐Congestive heart failure	☐Hypertension (high blood pressure)	☐Sleep apnea
☐Coronary artery disease	☐Inflammatory bowel disease	☐Thyroid disease
☐Crohn's disease	☐Irritable bowel syndrome	☐Ulcerative colitis
☐Deep vein thrombosis	☐Kidney disease	☐Other (specify)_____

Past Surgical History (Check any surgeries you have had and the date of surgery if you know it):

☐Appendectomy	☐Cosmetic surgery	☐Hysterectomy
☐Bariatric surgery	☐C-Section	☐Kidney transplant
☐Bowel resection	☐Eye surgery	☐Liver transplant
☐Breast surgery	☐Heart surgery	☐Orthopedic surgery
☐Cholecystectomy (gall bladder removal)	☐Hepatobiliary surgery	☐Sterilization
☐Colonoscopy	☐Hernia repair	☐Vascular surgery
☐Other (specify)_____		

FOR OFFICE STAFF: COLLECTED INFORMATION MUST BE ENTERED IN MICHART.
DISCARD FORM AFTER ENTRY, USING CONFIDENTIAL RECYCLE. DO NOT SEND TO HIM.

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Family History

Check below to report problems your family members have had. Please state the age when they had the problem if you know it.

☐I was adopted so I do not know my family history.

	Mother	Father	Sister	Brother	Son	Daughter	Other (list)
Alcohol abuse							
Breast cancer							
Cancer							
Celiac disease							
Colon cancer							
Colon polyps							
COPD (lung disease)							
Cystic fibrosis							
Diabetes							
Heart attack							
High cholesterol							
Hypertension							
Inflammatory bowel disease							
Irritable bowel syndrome							
Kidney disease							
Liver disease							
Other (specify)							
Alive (Yes, No, or N/A= Not Applicable							

Social History

Marital Status: ☐ Divorced ☐Legally Separated ☐Married ☐Significant other ☐Single

☐Widowed ☐Unknown ☐Other (specify):_____

What is your current occupation? _____

Do you ever drink alcohol? ☐Yes ☐No

If yes, please indicate the quantity per week of each:

- Glasses of wine _____
- Cans/bottles of beer _____
- Shots of liquor _____
- Drinks containing 0.5 oz of alcohol _____

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Are you sexually active? ☐Yes ☐No ☐Not currently

If yes, is/are your partner(s): ☐Male ☐Female ☐Both

Type of birth control/protection currently used:

☐Not having sex (Abstinence) ☐Condom ☐Injection ☐IUD (Intrauterine Device)

☐Oral Contraceptives (Pill) ☐Patch ☐Post-menopausal ☐None ☐Other (specify): _____

Do you use drugs? ☐Yes ☐No

If you use drugs, how many times per week? _____

What type(s) of drugs do you use? _____

Check one of the following about smoking tobacco:

☐Never smoked

☐Former smoker

☐Smoke some days

☐Smoke every day

☐Exposed to second hand smoke

If you smoke or used to smoke, how many packs do/did you smoke per day? _____

How many years did you smoke/have you smoked? _____

If you quit, when did you quit? _____

Do you use “smokeless tobacco”? (Select one below)

☐Former user

☐Current user

☐Never used

If you quit, when did you quit? _____

Are you ready to quit smoking and / or using smokeless tobacco? ☐Yes ☐No

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Review of Systems *Please check any current problems / symptoms you have experienced in the last 2 weeks:*

Constitutional	☐activity change ☐appetite change ☐chills ☐excessive sweating ☐fatigue ☐fever ☐unexpected weight change
Ears, nose, mouth, throat and face	☐hearing loss ☐nosebleeds ☐postnasal drip ☐dental problem ☐mouth sores ☐trouble swallowing
Eyes	☐eye redness ☐visual disturbance
Respiratory	☐stop breathing at night ☐chest tightness ☐choking ☐cough ☐shortness of breath ☐wheezing
Cardiovascular	☐chest pain ☐leg swelling ☐palpitations (racing heart beats)
Gastrointestinal	☐abdominal distention ☐abdominal pain ☐blood in stool ☐heartburn ☐liver problems ☐constipation ☐diarrhea ☐nausea ☐rectal pain ☐vomiting
Genitourinary	☐difficulty urinating ☐kidney stones ☐dysuria (painful urination) ☐enuresis (incontinence) ☐flank pain ☐blood in urine
Female Patients Only	☐menstrual problem ☐pelvic pain ☐vaginal bleeding ☐vaginal discharge ☐vaginal pain
Male Patients Only	☐penile discharge ☐scrotal swelling ☐testicular pain
Musculoskeletal	☐joint pain ☐back pain ☐gait problem ☐joint swelling ☐muscle weakness
Skin	☐color change ☐rash ☐wound
Neurologic	☐dizziness ☐headaches ☐light-headedness ☐numbness ☐seizures ☐speech difficulty ☐fainting ☐tremors ☐weakness ☐confusion
Hematologic (blood)	☐swollen lymph nodes ☐bleeds/bruises easily
Behavioral/Psychological	☐agitation ☐behavior problem ☐decreased concentration ☐nervous / anxious ☐self-injury ☐sleep disturbance ☐suicidal thoughts

_____ _____/_____/_____ (mm/dd/yyyy)

Printed name of person who completed this form Date

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