BROWN SURGICAL ASSOCIATES
BROWN PHYSICIANS, INC.

HEALTH HISTORY QUESTIONNAIRE

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Patient's Name:	**DOB:**	**AGE:**	**SEX:**

Reason for today's visit:

What is bothering you?

For how long?

How frequently does it happen?

Is it getting better or worse?

MEDICATIONS: PLEASE LIST ALL CURRENT MEDICATIONS WITH DOSAGE AND FREQUENCY

EXAMPLE: METFORMIN 10MG TWICE A DAY

NAME OF DRUG	DOSE	FREQUENCY
EXAMPLE: METFORMIN	***10MG***	***TWICE A DAY***

Allergies and Reactions

Allergy to Latex? YES_____ NO_____

Medication:	**Reaction:**

Patient's Name:	**DOB:**

PAST MEDICAL HISTORY: Please indicate if you have been diagnosed with any of these conditions:

	Y	N		Y	N		Y	N
AIDS/HIV			Emphysema/Bronchitis			Migraines/Headaches		
Anal Abscess			Epilepsy/Seizures			Osteoporosis		
Anal Fissure			Gallstones			Pacemaker		
Anal Fistula			Glaucoma			Pneumonia		
Angina/Chest Pain			GI Conditions			Prostate/Enlarged		
Anxiety/Rheumatism			Hearth Attack			Prostate Cancer		
Asthma			Heart Disease			Psoriasis		
Blood Cloths			Heart Valve Disease			Sickle Cell Disease		
Blood Disorder/Anemia			High Blood Pressure			Sleep Apnea		
Colon or Rectal Cancer			Heart Murmur			Stroke		
Colon or Rectal Polyps			Hemorrhoids			Thyroid Condition		
Crohn's Disease			Hepatitis B/Hepatitis C			Tuberculosis		
Defibrillator			Irregular Heart Beat			Ulcerative Colitis		
Dementia/Alzheimer's			Irritable Bowel Syndrome/IBS			Ulcers		
Depression			Irritable Bowel Disease/IBD			Urine Infections		
Diabetes			Kidney Disease/Failure			Vision/Hearing Issues		
Diverticulitis/Diverticulosis			Lung Disease					
Eczema			Mental Illness					

Personal History of Cancer	**Age**	**Type**	**Date Diagnosed**
	Yes	**No**	**Date treated**
Have you ever been diagnosed with MRSA?			

WOMEN: Age at onset of menstruation: _____ Date of last menstruation: _____

Number of Pregnancies: ___ Number of Live Births: ____ Number of Vaginal Deliveries: ____ Number of C-sections:_____

Were any of your children very big, long, or difficult deliveries? Yes No Forceps? _____ Vacuum? _____

Did you have a very large tear with lots of stitches? Yes No

Have you had a D&C or hysterectomy? Yes No

MEN:

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No

Please Indicate other known medical problems:

Patient's Name:	**DOB:**

Surgical and Colonoscopy History

	Yes	No	Date/Facility
Have you ever had a Colonoscopy?			
Have you ever had a Flexible Sigmoidoscopy?			

Procedure	**Date**	**Hospital/Physician**

Surgical Complications:

Have you ever had any major problems/reactions with Anesthesia? Yes_____ No _____

If you answered Yes, please explain: _____

Have you ever had any excessive bleeding problems with surgery? Yes _____ No _____

Hospitalizations

Reason	**Date**	**Hospital/Physician**

Patient's Name:	**DOB:**

Family History

Has anyone in your family been diagnosed with the following?

Diagnosis	**Relationship to you**	**Age of Diagnosis**
Colon or Rectal Cancer		
Ulcerative Colitis		
Crohn's Disease		
Polyps		
Familial Adenomatous Polposis (FAP)		
Cancer type:		
Cancer type:		
Other Diagnosis:		
Other History:		

Social History

Are you:	married	divorced	single	widowed	
Who do you live with?					
Do you have a living will?	No	Yes			
Do you smoke?	No	Yes	How many pack/day?	What age began?	
Have you ever smoked?	No	Yes	Date stopped:		
Do you vape?	No	Yes			
Do you drink?	No	Yes	Frequency?	Amount?	Type?
Do you use recreational drugs?	No	Yes	Type of drug:		

Gastrointestinal History

Diarrhea	Y	N		Constipation	Y	N	
Visible blood with bowel movement:		Y	N	Dark Maroon		Bright Red	(circle answer)
Pain with defecation:	Y	N		Sharp	Achy	Burning	(circle answer)
Anal Itching	Y	N					
Do you have stool incontinence or accidents?			Y	N	How often:		
Do you have minor spotting or soiling?			Y	N	How often:		
How often do you move your bowels?	_____		Bowel Movements are:	normal	hard	soft	loose watery
Do you take laxatives:	Y	N	Name: _____		Frequency: _____		
Do you take or use:	enema		suppository		How often: _____		

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Patient's Name:	**DOB:**

REVIEW OF SYSTEMS: Please indicate all that apply to you

Constitutional symptoms	**Y**	**N**	**Ear, Nose, Throat**	**Y**	**N**	**Neurological**	**Y**	**N**
Weight gain			Hearing Loss			Headaches		
Weight loss			Nose Bleeds			Dizziness/Vertigo		
Fevers			Sore throat			Seizures		
Night Sweats			Pain Swallowing			Weakness		
Fatigue						Numbness		
Loss of appetite								
Cardiac	**Y**	**N**	**Genitourinary**	**Y**	**N**	**Psychiatric**	**Y**	**N**
Chest pain/heaviness			Frequent voiding			Depression		
Shortness of breath with activity			Pain with voiding			Anxiety		
Shortness of breath at rest			Blood in urine			Mood Changes		
Irregular heart beat/palpitations			Sexual dysfunction			Memory Problems		
Lightheadedness/fainting			Groin pain					
Gastrointestinal	**Y**	**N**	**Hematologic**	**Y**	**N**	**Breast Health**	**Y**	**N**
Abdominal pain			Abnormal bleeding/bruising			Breast cysts/lumps		
Nausea			Clotting problems			Breast skin changes		
Vomiting			Transfusion problems			Nipple discharge		
Heartburn			Anemia			Breast pain		
			Blood clots			Recent mammogram - Date		
Endocrine	**Y**	**N**	**Skin & Integumentary**	**Y**	**N**	**Ob/GYN**	**Y**	**N**
Heat/cold intolerance			Rashes			C-section?		
Excessive thirst			Sores			Menstrual period regular		
Excessive voiding			Blisters			Menstrual period irregular		
Excessive appetite			Growths			Postmenopausal		
Excessive hair growth			Hair loss			Recent PAP smear		
						If yes, approximate date:		
Musculoskeletal	**Y**	**N**	**Respiratory**	**Y**	**N**			
Joint pain/swelling			Cough					
Stiffness			If Yes, check all that applies:					
Weakness of limbs			___ Dry ___ Bloody			**OTHER:**	**Y**	**N**
Back pain/sciatica			___ Green ___ White			Have you ever had any bleeding problems?		
Gout			___ Voice Change ___ None					
						Have you ever had a blood transfusion?		
Eye, Vision	**Y**	**N**	Wheeze					
Double Vision			Shortness of breath			Have you had any anesthesia problems?		
Visual Changes			Blood in sputum					
			Early waking/snoring			Do you have any metal implants?		

Thank you for providing us with this important information

Signature: _____ Date: _____