Carlisle Digestive Disease Associates, Ltd. **Health History Form**

Dear _____: Date of Birth ___/___/_____

In order to assure that we have accurate and up to date information regarding your medical history, please complete this form to the best of your ability and bring it with you to your appointment on _____.

Are you currently taking:	warfarin (Coumadin)	□ Yes	□ No
	Plavix (clopidrogrel)	□ Yes	□ No
	Aspirin	□ Yes	□ No
	NSAIDS (ibuprofen, naproxen, Motrin, Aleve)	□ Yes	□ No
If you are a female, are you currently pregnant?		□ Yes	□ No
Have you ever had an adverse reaction to anesthesia?		□ Yes	□ No
Do you have any allergies to medications, foods or latex?		□ Yes	□ No

If yes, please list:_____

Please list your current medications(include dose and frequency):

_____ _____

_____ _____

_____ _____

_____ _____

Do you currently have or have you ever had any of the following medical conditions?:

Heart Disease	□ Yes	No
If yes: Have you ever had a heart attack?	□ Yes	No
Do you have a pacemaker/defibrillator?	□ Yes	No
Lung Disease	□ Yes	No
(including asthma, emphysema, chronic bronchitis)		
Sleep Apnea	□ Yes	No
High Blood Pressure	□ Yes	No
Diabetes	□ Yes	No
HIV (AIDS)	□ Yes	No
Kidney Disease	□ Yes	No
Seizure Disorder	□ Yes	No
Cancer	□ Yes	No
If yes, please state what type_____		
Stroke or TIA	□ Yes	No
If yes, describe any residual deficits, if present_____		
Hepatitis or Liver Disease	□ Yes	No
Blood Disorders or Blood Clots	□ Yes	No
Emotional Problems – Please Circle	□ Yes	No
(anxiety, depression, claustrophobia or trouble with your nerves)		
Thyroid Disorder	□ Yes	No
Autoimmune disorders (lupus, arthritic conditions)	□ Yes	No
Infectious Diseases (TB, MRSA or C. difficile)	□ Yes	No
If yes, please circle		
Have you taken an antibiotic within the past 6 months	□ Yes	No

CONTINUED ON OTHER SIDE

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Please list any other past or present medical conditions or problems: _____

_____

_____

_____

Please list any prior surgical procedures or hospitalizations: _____

_____

_____

_____

_____

Do you smoke? Yes No If yes, how much? _____

Do you use alcohol? Yes No If yes, average drinks per week _____

Have you had any recent problems with:

Weight loss	Yes	No	Mouth sores	Yes	No
Fever	Yes	No	Excessive thirst or urination	Yes	No
Chest pain	Yes	No	Poor appetite	Yes	No
Shortness of breath	Yes	No	Difficulty swallowing	Yes	No
Palpitations	Yes	No	Heartburn	Yes	No
Ankle swelling	Yes	No	Nausea	Yes	No
Wheezing	Yes	No	Vomiting	Yes	No
Chronic cough	Yes	No	Bloating	Yes	No
Blood in urine	Yes	No	Belching	Yes	No
Burning with urination	Yes	No	Regurgitation	Yes	No
Rash	Yes	No	Constipation	Yes	No
Itching	Yes	No	Diarrhea	Yes	No
Joint pain	Yes	No	Abdominal pain	Yes	No
Back pain	Yes	No	Change in bowel habits	Yes	No
Headaches	Yes	No	Rectal bleeding	Yes	No
Memory Loss	Yes	No	Black, tarry stools	Yes	No
Anemia	Yes	No	Incontinence (leakage of stool)	Yes	No

Please list the name of your primary care physician and any other health care providers to whom we should send records: _____

_____

Is there anything else that you would like to bring to our attention? Yes No

If yes, please specify: _____

_____

_____

_____

Have you had any recent or pertinent tests or procedures done (i.e. blood work, x-rays, endoscopies, CT scans, etc.)? If so, please specify:

Date	Test	Facility
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Form: 07/16/2014