Name: _____

Date of Birth: _____

Today's Date: _____

Health History Form – New Patient

Thank you for choosing our clinic for your healthcare needs. We appreciate your assistance with completing this form as it will help us better care for you. This is confidential information to be kept in your electronic medical record.

What is the reason for your visit?

_____

_____

What symptoms are you having and how often are they occurring?

_____

_____

Are you taking any medications for this diagnosis? If so, what are you taking and is it working?

_____

Have you seen a gastroenterologist before: ☐ Yes ☐ No

If yes, who did you see? _____

Who is your primary care physician? _____

Who referred you to BSW Digestive Diseases – Fort Worth? _____

Allergies

Please list any allergies you have (food or drug) and indicate the type of reaction.

_____

_____

_____

Pharmacy

Preferred Pharmacy: _____ Phone: _____

Address: _____

Medications

Please list your current medications and dosages (include herbal medications, dietary supplements, vitamins, Tylenol, Ibuprofen, injectables/infusions and other over-the-counter medications)

Medication name	Dose and Frequency

Medical History / Review of Systems

Please check all that apply.

☐Melanoma

☐Broken Bone(s)

☐Osteopenia

☐Osteoporosis

☐Abnormal Pap Smear

☐Diabetes

☐High Blood Pressure

☐Multiple Sclerosis

☐Lupus

☐Thyroid Disease

☐Heart Attack

☐Heart Arrhythmia

☐Heart Failure

☐Stroke

☐Emphysema/COPD

☐Asthma

☐Pancreatitis

☐Kidney Disease

☐Tuberculosis

☐Depression

☐Anemia

☐Vitamin D deficiency

☐Vitamin B12 deficiency

☐Weight Loss (_____ lbs)

☐Weight Gain (_____ lbs)

☐Fevers

☐Chills

☐Weakness

☐Fatigue

☐Night Sweats

☐Skin Rashes/Sores/Blisters (circle option that applies)

☐Psoriasis

☐Vision Loss

☐Double Vision

☐Eye Redness (Episcleritis)

☐Eye Pain (Uveitis)

☐Ear Aches

☐Runny Nose

☐Sinus Pain

☐Seasonal Allergies

☐Oral Ulcers

☐Sore Throat

☐Difficulty/Painful Swallowing

☐Cough

☐Difficulty Breathing

☐Wheezing

☐Chest Pain
☐Swelling in Legs/Feet
☐Rapid Heart Beat
☐Heartburn
☐Acid Reflux
☐Pelvic Pain
☐Endometriosis
☐Joint Pain/Swelling
☐Back Pain
☐Sickle Cell
☐Prior Blood Transfusion(s)
☐Swelling of Glands
☐Easy Bleeding
☐Heat/Cold intolerance
☐Excessive Sweating

☐Regurgitation
☐Nausea/Vomiting
☐Bloating
☐Abdominal Pain
☐Constipation
☐Migraines
☐Headaches
☐Seizures
☐Fainting
☐Head Trauma
☐Numbness in hands or feet
☐Anxiety
☐Panic
☐Hopelessness
☐Racing Thoughts

☐Diarrhea
☐Rectal Bleeding
☐Blood in Urine
☐Painful Urination
☐Insomnia
☐Non-Restorative Sleep
☐Snoring
☐Hepatitis A / B / C
☐Perianal Fistula
☐Deep Vein Thrombosis
☐Pulmonary Embolism
☐Pneumonia
☐Kidney Stones

Other: _____

Please list any surgeries with dates:
_____
_____
_____

Family History

☐No knowledge of family history ☐Adopted

Please list family medical history below, be sure to include any GI issues.

	Medical Problems	Deceased	If deceased, cause of death
Mother			
Father			
Sibling			
Sibling			

Sibling			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Social History

Do you smoke? ☐Yes ☐No ☐Former

Do you use chewing tobacco? ☐Yes ☐No ☐Former

Do you drink alcohol? ☐Daily ☐Socially ☐Never ☐Former

Do you use recreational/street drugs? ☐Daily ☐Socially ☐Never ☐Former

Type: _____

Immunizations

When was your last flu vaccine? _____

Have you ever received a pneumonia vaccine (Pneumovax)? If yes, when? _____

Have you ever received a Hepatitis A vaccine? If yes, when? _____

Have you ever received a Hepatitis B vaccine? If yes, when? _____

Have you ever received a Shingles vaccine? If yes, when? _____

Have you ever had a tuberculosis skin test? If yes, when and what was the result? _____

Have you ever had a tuberculosis blood test? If yes, when and what was the result? _____