1015 S. Hackett Rd.
Waterloo, Iowa 50701
319.234.5990

DigestiveHealthCenter.com

DHC
DIGESTIVE HEALTH CENTER

Patient Health History

NAME: ____________ DATE OF BIRTH: ________ AGE: ________
REFERRED BY: ____________ PRIMARY DOCTOR: ____________
REASON FOR TODAY'S VISIT: ____________ TODAY'S DATE: ________

MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER):

Strength, Route, Frequency. *Ex. Asprin, 81 mg, 1 tablet by mouth daily*

____
____
____
____
____
____
____

NON-STEROIDAL DRUG USE? ☐ YES ☐ NO
(Ex: Aleve, Ibuprofen, Motrin, etc.)
DO YOU TAKE ASPIRIN? ☐ YES ☐ NO
DO YOU USE HERBAL PRODUCTS? ☐ YES ☐ NO
DO YOU TAKE MULTIVITAMINS? ☐ YES ☐ NO
DO YOU TAKE BLOOD THINNERS? ☐ YES ☐ NO

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY):

☐ HEART DISEASE ☐ ASTHMA
☐ DIABETES: ________ ☐ ARTHRITIS
☐ LUNG DISEASE/COPD ☐ COLON POLYPS
☐ HIGH BLOOD PRESSURE ☐ COLON CANCER
☐ KIDNEY DISEASE ☐ SEIZURES/EPILEPSY
☐ CELIAC DISEASE ☐ GLAUCOMA
☐ COLITIS/CROHN'S DISEASE ☐ CONGESTIVE HEART FAILURE
☐ STROKE ☐ THYROID DISEASE
☐ HEPATITIS/LIVER DISEASE
☐ CANCER – TYPE: ____________
☐ OTHER: ____________

FEMALES – IS THERE ANY CHANCE THAT YOU ARE PREGNANT? ☐ YES ☐ NO

ALLERGIES: Substance & Reaction

☐ ____________
☐ ____________
☐ ____________
☐ ____________
☐ ____________

Have you ever had an unusual reaction to a general or local anesthetic? ☐ YES ☐ NO
Explain: ____________
Have you ever received a blood or a blood-product transfusion?
☐ YES ☐ NO Year: ________

PREVIOUS SURGERIES/PROCEDURES (CHECK ALL THAT APPLY)

☐ HERNIA ☐ BACK
☐ APPENDIX ☐ TONSILS
☐ GALLBLADDER ☐ BREAST
☐ HYSTERECTOMY ☐ PACEMAKER IMPLANTED
☐ TUBAL LIGATION ☐ DEFIBRILLATOR IMPLANTED
☐ HIP REPLACEMENT ☐ KNEE REPLACEMENT
☐ HEART BYPASS SURGERY ☐ HEART VALVE REPLACED
☐ EGD – DATE: ____________
☐ COLONOSCOPY – DATE: ____________
☐ COLON, INTESTINAL, STOMACH SURGERY —
DATE: ____________
☐ OTHER: ____________

Over

FAMILY HISTORY (CHECK ALL THAT APPLY):

Condition	Who
☐ CELIAC DISEASE	WHO: ________________
☐ COLITIS/CROHN'S DISEASE	WHO: ________________
☐ COLON POLYPS	WHO: ________________
☐ COLON CANCER	WHO: ________________
☐ LIVER DISEASE/PROBLEMS	WHO: ________________
☐ CANCER	WHO/TYPE: ____________
☐ HIGH BLOOD PRESSURE	WHO: ________________
☐ KIDNEY DISEASE	WHO: ________________
☐ HEART DISEASE	WHO: ________________
☐ LUNG DISEASE	WHO: ________________
☐ DIABETES	WHO: ________________
☐ STROKE	WHO: ________________

SOCIAL HISTORY:

MARITAL STATUS	☐ M	☐ S	☐ D	☐ W
CAFFEINE	☐ YES	☐ NO	QTY:	___________
SMOKE	☐ YES	☐ NO	QTY:	___________
TATTOOS	☐ YES	☐ NO	YEAR:	___________
OCCUPATION: ______________________________________				
ALCOHOL	☐ YES	☐ NO	QTY:	___________
IV DRUG USE	☐ YES	☐ NO	WHEN:	___________

Do you feel threatened, abused, neglected or exploited in your home? ☐ YES ☐ NO

REVIEW OF SYMPTOMS – PLEASE CHECK YES OR NO TO ALL QUESTIONS:

CONSTITUTIONAL:

WEIGHT LOSS	☐ YES	☐ NO
WEIGHT GAIN	☐ YES	☐ NO
FEVER	☐ YES	☐ NO
CHILLS	☐ YES	☐ NO

EYES:

REDNESS	☐ YES	☐ NO
DOUBLE OR BLURRED VISION	☐ YES	☐ NO

ENT:

HOARSENESS	☐ YES	☐ NO
TROUBLE SWALLOWING	☐ YES	☐ NO

HEMATOLOGIC/LYMPHATIC:

BRUISING	☐ YES	☐ NO
BLOOD CLOTS	☐ YES	☐ NO
ANEMIA	☐ YES	☐ NO

RESPIRATORY/CARDIOVASCULAR:

EDEMA	☐ YES	☐ NO
SHORTNESS OF BREATH	☐ YES	☐ NO
CHEST PAIN	☐ YES	☐ NO

NEUROLOGICAL:

HEADACHES	☐ YES	☐ NO
DIZZINESS	☐ YES	☐ NO
HISTORY OF FALLS	☐ YES	☐ NO

OTHER: ________________________________

GASTROINTESTINAL:

NAUSEA	☐ YES	☐ NO
VOMITING	☐ YES	☐ NO
ACID REFLUX	☐ YES	☐ NO
HEARTBURN	☐ YES	☐ NO
DIARRHEA	☐ YES	☐ NO
CONSTIPATION	☐ YES	☐ NO
BLOOD IN STOOL	☐ YES	☐ NO
ABDOMINAL PAIN	☐ YES	☐ NO
ABDOMINAL BLOATING	☐ YES	☐ NO

MUSCULOSKELETAL:

BACK PAIN	☐ YES	☐ NO
CHEST PAIN	☐ YES	☐ NO
WEAKNESS	☐ YES	☐ NO
JOINT PAIN/SWELLING	☐ YES	☐ NO

UROLOGY:

BLADDER PROBLEMS	☐ YES	☐ NO
KIDNEY DISEASE	☐ YES	☐ NO

INTEGUMENTARY:

SKIN RASH	☐ YES	☐ NO

PSYCHOLOGICAL:

ANXIETY	☐ YES	☐ NO
DEPRESSION	☐ YES	☐ NO
MEMORY LOSS	☐ YES	☐ NO

PATIENT SIGNATURE: ______________________________________ DATE: ____________________

NURSE SIGNATURE: ______________________________________ DATE: ____________________

PROVIDER SIGNATURE: ______________________________________ DATE: ____________________

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