Hillside Gastroenterology & Nutrition, Inc.
Health Questionnaire

Name: _____
Date: _____

*** Family History:** *If any blood relative has suffered any of the following – Please circle & indicate which relative*

Diabetes _____ Stroke _____ Heart Disease _____
High Blood Pressure_____ High Cholesterol _____ Alcoholism _____
Crohn's Disease _____ Cancer _____ Ulcerative Colitis _____
Celiac Disease _____ Obesity _____ Anesthesia Problems _____

*** Major Illnesses: (***Please list year <u>and</u> illness)*

_____
_____
_____
_____

Operations: (Please list year <u>and</u> operation)*

_____
_____
_____
_____

*** Current Medical Symptoms: (***Please check if you have experienced any of the following in the past month)*

____ Change in vision ____ Vomiting ____ Numbness
____ Hearing loss ____ Frequent urination ____ Headaches
____ Shortness of breath ____ Fatigue ____ Joint aches
____ Chest pain ____ Weight change ____ Rashes
____ Nausea ____ Appetite change ____ Depression

***Do you exercise?** _____NO _____YES

***Do you smoke cigarettes?** _____NO _____YES If yes, how many per day? _____

***During the past month, how many alcoholic beverages did you typically have in one week?** _____

***Do you use any recreational drugs?** _____ NO ____YES

Yes	No	**PAST MEDICAL HISTORY**	Yes	No	**PAST MEDICAL HISTORY**
☐	☐	Heart Disease	☐	☐	Diabetes
☐	☐	High Blood Pressure	☐	☐	Cancer
☐	☐	Liver Disease / Hepatitis	☐	☐	Seizures
☐	☐	Heart Valve Problems / Artificial Valve	☐	☐	Glaucoma
☐	☐	Pacemaker / Internal Defibrillator	☐	☐	Bleeding / Clotting Disorder
☐	☐	Lung Disease / Asthma / Sleep Apnea	☐	☐	Artificial Joints or Limbs
☐	☐	Kidney Disease	☐	☐	Pregnant ☐ NA
☐	☐	Gastrointestinal Disease	☐	☐	History of Drug Resistant Organisms (MRSA)
Other:			Other:		