Hillside Gastroenterology & Nutrition, Inc.
Health Questionnaire

Patient Name:_______________________________

Date:__________________________

Hillside Endoscopy Center, LLC
250 Fame Ave, Suite 240
Hanover, PA 17331
717-633-9086
Entrance F

FAMILY HISTORY

(If any blood relative has suffered any of the following, please circle and indicate relative)

Diabetes:__________________ Stroke Heart Disease:________ Heart Disease:______________
High Blood Pressure:__________ High Cholesterol:___________ Alcoholism:________________
Crohn's Disease:______________ Cancer:___________________ Ulcerative Colitis:____________
Celiac Disease:_______________ Obesity:__________________ Anesthesia Problems:_________

PATIENT HISTORY

Major Illnesses:	Date:	Surgeries:	Date:

CURRENT MEDICAL SYMPTOMS:

(Please check if you have experienced any of the following in the past month)

Vision Changes______ Vomiting ______ Numbness ______
Hearing loss______ Frequent urination ______ Headaches ______
Shortness of breath ______ Fatigue ______ Joint Aches ______
Chest pain/pressure ______ Weight changes ______ Rashes______
Nausea______ Appetite changes ______ Depression ______

Do you have any issues with Anesthesia? Yes______ No______ *If yes,* explain:________________________________

Current Habits:

Do you exercise regularly? Yes______ No______
Do you smoke/vape? Yes______ No______ *If yes*, how many per day?______________ Years smoked/vaped_____________
Do you drink Alcohol? Yes______ No______ *If yes*, how many drinks per week? ______________
Do you use recreational drugs? Yes______ No______ *If yes*, explain:________________________________

Past Medical History:

Heart Diseases YES______ NO______	Gastrointestinal Disease YES______ NO______
High Blood Pressure YES______ NO______	Diabetes YES______ NO______
Liver Disease/Hepatitis YES______ NO______	Cancer YES______ NO______
Heart Valve Problems YES______ NO______	Seizures YES______ NO______
Artificial Valve/Replacement YES______ NO______	Glaucoma YES______ NO______
Pace Maker/Defibrillator YES______ NO______	Bleeding/Clotting Disorder YES______ NO______
Lung Disease *(Asthma, COPD,etc)* YES______ NO______	Artificial Joints/Limbs YES______ NO______
Sleep Apnea YES______ NO______	History of Drug Resistant Organisms *(MRSA,VRE, etc)* YES______ NO______
Kidney Disease YES______ NO______	**Women Only:** Have you had any past pregnancies? YES______ NO______
Other:______________________________	Other:______________________________