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The following questions are designed to obtain some general information about your health history. Please complete the FRONT and the BACK of ALL pages.

Your appointment has been scheduled for ___________________ at _______________a.m./p.m.

PATIENT INFORMATION (Please print or type)

Name: ____ Sex: [ ] Male [ ] Female

Street address: ____

City: ___________________________________ State: _______________ Zip: ________________

Last 4 digits of SS #: ________________ Driver's License #: _____________________________

Home phone: ____________________________ Cell Phone: _____________________________

Email address: ___________________________ Date of Birth: ____________________________

Person to notify in case of emergency: ____

Address: ______________________________________ Phone Number: ___________________

Relationship: ____

Person responsible for payment of your professional fees: [ ] myself [ ] other

Name of other person responsible: _____________________ Phone Number: _______________

Relationship: ____

Referred by: ____

If you have insurance coverage, please indicate the type(s):

[ ] Medicare

- **Medicare Number: ____________________________________**

[ ] Blue Cross/Blue Shield

- **BC/BS Member ID Number: ____________________________**

[ ] Other insurance coverage: ____________________________________

- **Member ID Number: __________________________________**

DESCRIBE YOUR INTESTINAL PROBLEM(S)

____

____

____

____

PREVIOUS SURGERY:

Place a mark in the box next to the type of surgery you have had and the approximate date of the surgery.

[ ] Appendectomy	[ ] Hiatal hernia repair
[ ] Colon surgery	[ ] Hemorrhoids
[ ] Cardiac pacemaker	[ ] Hysterectomy
[ ] Gastric bypass	[ ] Stomach surgery
[ ] Gallbladder removal	[ ] Colonoscopy (date____________)
[ ] Heart stent placement	[ ] Upper endoscopy (date__________)
[ ] Sinus surgery	[ ] Tonsillectomy

PREVIOUS MEDICAL PROBLEMS:

Place a mark in the box next to the illness or illnesses that you currently have or have had in the past.

Crohn's disease	Heart murmur	Rheumatic fever
Ulcerative colitis	High cholesterol	Rheumatoid arthritis
Uterine cancer	High blood pressure	Hemorrhoids
Esophageal reflux	Irritable bowel syndrome	Anemia
Helicobacter pylori	Chronic diarrhea	Emphysema
Duodenal ulcer	Gallstones	Eating disorder
Colon polyp(s)	Pancreatitis	Radiation therapy
Esophageal varices	Diverticulitis	Thyroid disease
Fibromyalgia	Kidney stones	Migraine headaches
Heart attack	Stroke	Abnormal heart rhythm
Diabetes	Cancer	Ulcer disease
Recurrent sinusitis	Bleeding gums	Hepatitis

FAMILY HISTORY

- Is your mother living? [ ] Yes [ ] No (cause of death): ____________________
- Is your father living? [ ] Yes [ ] No (cause of death): ____________________
- Have any of your relatives been diagnosed with cancer before the age of 50? [ ] Yes [ ] No
- Have any immediate family members (mother, father, brother, sister, child) had any of the below conditions regardless of age?

[ ] Breast cancer [ ] Ulcerative colitis [ ] Colon cancer
[ ] Heart attack before age 50 [ ] Colon polyps [ ] Hypertension
[ ] Crohn's disease [ ] Ovarian cancer [ ] Diabetes

ALCOHOL AND TOBACCO

- **Do you drink alcohol? [ ] Yes [ ] No**

- **If “Yes”, how much alcohol do you drink in a week?**
  _____ cans of beer per week _____ glasses of wine per week
  _____ ounces of liquor per week
- **Do you use tobacco products? [ ] Yes [ ] No**
- **If “Yes”, what kind? [ ] Cigarettes _________ packs/day [ ] Snuff**
  [ ] Chewing tobacco [ ] Pipe [ ] Cigars [ ] Vaping

BOWEL MOVEMENTS:

- **How many bowel movements do you usually have each day? ____________**
- **Have you had any recent change in the frequency of your bowel movements? [ ] Yes [ ] No**
- **Have you recently been experiencing constipation? [ ] Yes [ ] No**
- **Have you recently been having diarrhea? [ ] Yes [ ] No**
- **Have you been experiencing more than three bowel movement a day?**
  [ ] Yes [ ] No
- **Have you had any loss of control of your bowel movements recently?**
  [ ] Yes [ ] No
- **Have you seen any blood appear in or on the stool or on the toilet tissue or in the toilet water in the last month? [ ] Yes [ ] No**
- **Do you have abdominal cramping associated with your bowel movements?**
  [ ] Yes [ ] No
- **Does the need to have a bowel movement cause you to awaken from sleep?**
  [ ] Yes [ ] No

HEIGHT AND WEIGHT

- **How tall are you? ______________________**

- **What is the most that you have weighed in the last 12 months?**
  ____
- **What is the least that you have weighed in the last 12 months?**
  ____
- **What is your current weight? _________________**

WATER SUPPLY

- **Is your residence supplied by city water or well water? (Check one)**

  [ ] city water [ ] well water

- **If your water supply comes from a well, have you had the water tested for contamination by your county health department in the last year?**

  [ ] Yes [ ] No

NON-PRESCRIPTION MEDICATIONS

Do you take any of the following non-prescription items? Check those that apply.

[ ] Vitamin D [ ] Acid reducing medications
[ ] Probiotics [ ] Multivitamin
[ ] B12 [ ] Other over-the-counter supplements
[ ] Aspirin [ ] Non prescription pain medications
(Examples, Advil, Ibuprofen, Aleve, Motrin, Bufferin, Excedrin)

OTHER DRUGS

In the last year have you used any of the following recreational drugs?

[ ] Marijuana [ ] Methamphetamines
[ ] LSD [ ] Methadone
[ ] Cocaine [ ] Opioids

BEVERAGES CONSUMED

- **Do you drink coffee? If so, how many cups per day?**

  [ ] None [ ] 1-3 [ ] more than 3

- **Do you drink black tea? If so, how many cups a day? [ ] None [ ] 1-2 [ ] more than 2**

- **Do you drink green tea? If so, how many cups a day?**

  [ ] None [ ] 1-2 [ ] more than 2

- **Do you drink cola drinks? If so, how many cola drinks per day?**

  [ ] None [ ] 1-3 [ ] 4-6 [ ] More than 6

- **Do you drink carbonated beverages other than cola drinks? If so, how many per day? [ ] None [ ] 1-3 [ ] 4-6 [ ] More than 6**

- **Do you drink energy drinks more than twice a week such as Monster®, Red Bull®, or Jolt®? [ ] Yes [ ] No**

- **Do you drink any beverages that contain artificial sweeteners?**

  [ ] Yes [ ] No

- **Do you regularly use artificial sweeteners in or on your food?**

  [ ] Yes [ ] No

DIAGNOSTIC STUDIES

- **Have you had any of the following imaging studies done in the last 12 months? Check those that apply:**

  [ ] CT scan **[ ] Bone density study**

  [ ] MRI scan **[ ] Upper endoscopy**

  [ ] Gallbladder sonogram **[ ] Colonoscopy**

ALLERGIES

- **Do you have any drug allergies? [ ] Yes [ ] No If so, please specify**

  ____

  ____

- **Do you have any food allergies? [ ] Yes [ ] No If so, please specify**

  ____

  ____

- **Have you had multiple infections of the nose? [ ] Yes [ ] No**

INTESTINAL SYMPTOMS

In the last month, have you had any of the following symptoms? Check those that apply:

[ ] Nausea [ ] Night sweats

[ ] Vomiting [ ] Involuntary weight loss of more than 5 pounds

[ ] Heartburn [ ] Difficulty swallowing [ ] Loss of appetite

DENTAL HISTORY

- Since you were born, how many dental cavities have been filled?
  [ ] None [ ] 1-3 [ ] 4-7 [ ] 7-10 [ ] More than 10
- Have you ever needed any dental caps/crowns? [ ] Yes [ ] No
  If so, how many? [ ] 1-3 [ ] 4-6 [ ] 7-10 [ ] More than 10
- Have you ever had any root canal procedures? [ ] Yes [ ] No
  If so, how many? [ ] 1-3 [ ] 4-6 [ ] 7-10 [ ] More than 10
- How frequently do you go to the dentist? [ ] Less than once a year
  [ ] Once a year [ ] Twice a year [ ] More than twice a year
- How frequently do you have your teeth cleaned by the dental hygienist?
  [ ] Less than once a year [ ] Once a year
  [ ] Twice a year [ ] More than twice a year
- Do you have a history of recurrent bleeding gums? [ ] Yes [ ] No
- Have you ever been under the care of a periodontist (gum specialist)?
  [ ] Yes [ ] No
- Do you frequently have mouth sores (canker sores)? [ ] Yes [ ] No
- Do you wear dentures? [ ] Yes [ ] No
- Do you have any dental bridges? [ ] Yes [ ] No
- Do you use an electronic rechargeable toothbrush? [ ] Yes [ ] No
- Do you use a standard bristle toothbrush? [ ] Yes [ ] No
- How long do you take to brush your teeth? Check one that applies.
  - [ ] Unknown
  - [ ] Less than 30 seconds
  - [ ] Greater than 30 seconds but less than one minute
  - [ ] More than one minute but less than two minutes
  - [ ] Two minutes or longer
- Do you have any dental implants? [ ] Yes [ ] No
  If so, how many? [ ] 1-3 [ ] 4-6 [ ] 7-10 [ ] More than 10

- **Name of your dentist: ____**

  Address: ____

  City, state, zip code: ____

  Phone number: ____

ANTIBIOTIC USAGE

- **How many times in the last five years do you think that you have been prescribed antibiotics?**

  [ ] None [ ] 1-5 times [ ] 6-12 times [ ] More than 12 times
- **Have you ever used antibiotics for more than 10 days in a row at any time in your life? [ ] Yes [ ] No**

COVID STATUS

- **Have you had COVID infection? [ ] Yes [ ] No**
- **Have you received COVID vaccine? [ ] Yes [ ] No**

  If "YES" which ones—check all that apply: [ ] Original 2 [ ] Booster 1 [ ] Booster 2 [ ] Bivalent Booster 3

MENTAL HEALTH

- **Have you ever been diagnosed with anxiety? [ ] Yes [ ] No**
- **Have you ever been diagnosed with depression? [ ] Yes [ ] No**
- **Do you currently see a mental health advisor? [ ] Yes [ ] No**
- **Have you ever been diagnosed with Attention Deficit Disorder?**

  [ ] Yes [ ] No
- **Have you ever been diagnosed with an eating disorder? [ ] Yes [ ] No**

LIST ALL MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE INCLUDING VITAMINS, MINERALS, PROBIOTICS, ETC.

	STRENGTH	# OF TIMES TAKEN DAILY
Example: Vitamin D	*1000 I.U.*	*Once*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		

EARLY FORMATIVE YEARS

In many cases, precursors of illnesses that occur in adulthood can be traced to events that occurred in the earliest parts of life. A brief history of your formative years may help with diagnosis and/or treatment. Please answer the following questions to the best of your knowledge. Were you born prematurely or full term?

[ ] Premature [ ] Full term [ ] Unknown

Were you born by natural childbirth or by Cesarean section? [ ] Natural childbirth [ ] Cesarean section [ ] Unknown

Were you bottle fed or breast fed for the first three months of life? [ ] Bottle fed [ ] Breast fed [ ] Unknown

Were you considered a colicky infant i.e., your care providers had difficulty finding a feeding formula that you tolerated?

[ ] Yes [ ] No [ ] Unknown

Were you hospitalized for any type of illness during the first five years of your life?

[ ] Yes [ ] No [ ] Unknown

Did you have any surgery during the first five years of life?

[ ] Yes [ ] No [ ] Unknown

During the first five years of life, did you receive frequent antibiotics for any of the following: respiratory illnesses, tonsillitis, strep throat, middle ear infections, urinary tract infections or other infections?

[ ] Yes [ ] No [ ] Unknown

Did you require drain tubes placed in your ears for recurrent ear infections during the first five years of your life?

[ ] Yes [ ] No [ ] Unknown

Did you ever miss attending school for more than five consecutive days for any illness up until age 18?

[ ] Yes [ ] No [ ] Unknown

Were you diagnosed with asthma at any time before age 13?
[ ] Yes [ ] No [ ] Unknown

Was there ever a time in the first 18 years of your life when you felt there was a shortage of food in your household, and that you went hungry?
[ ] Yes [ ] No [ ] Unknown

Did you ever receive radiation treatments before the age of 18 for any condition?
[ ] Yes [ ] No [ ] Unknown

Has a medical care provider advised you to make any modifications to your diet in the last 12 months?
[ ] Yes [ ] No If "yes", please summarize those changes:

____

____

____

____

____

Have you made any recent modifications to your diet in the last 12 months? [ ] Yes [ ] No If "yes", please summarize those changes:

____

____

____