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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: _____

Social Security #:_____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

Other person responsible: _____

Address: _____ Phone Number: _____

Relationship: _____

Referred by: _____

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

[ ] Medicare [ ] Medicare Number:_____

[ ] Blue Cross/Blue Shield [ ] Contract Number:_____

[ ] Other insurance coverage: (list name of carrier and contract numbers here)

_____

_____

DESCRIBE YOUR INTESTINAL PROBLEM(S)

_____

_____

_____

_____

_____

PREVIOUS SURGERY: (Place a mark in the box next to the type surgery you have had and the approximate date of the surgery)

[ ] Appendectomy	[ ] Hernia repair
[ ] Colon surgery	[ ] Hemorrhoids
[ ] Cardiac pacemaker	[ ] Hysterectomy
[ ] Gastric bypass	[ ] Stomach surgery
[ ] Gallbladder removal	[ ] Colonoscopy
[ ] Heart stent placement	[ ] Upper endoscopy
[ ] Sinus surgery	[ ] Nose surgery

PREVIOUS MEDICAL PROBLEMS:

Please 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

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

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?
  [ ] 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 [ ] Daily 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 [ ] Opiods

SLEEP HABITS

- What time do you usually go to sleep? _____
- Do you have difficulty falling asleep? [ ] Yes [ ] No
- Do you take any sleep aid medications? [ ] Yes [ ] No
- What time do you usually awaken from sleep for the day? _____
- Do you have sleep apnea? [ ] Yes [ ] No
  If yes, do you use a CPAP breathing assist machine? [ ] Yes [ ] No
- How many times do you usually arise from sleep to urinate? [ ] None
  [ ] 1-2 [ ] 3-5 [ ] more than 5

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 [ ] 1-3 [ ] more than 3
- Do you drink cola drinks? If so, how many cola drinks per day? Examples: Coca Cola®, Pepsi Cola®, Sprite®, 7 UP®, Ginger Ale®, etc.

  [ ] None [ ] 1-3 [ ] 4-6 [ ] More than 6
- Do you drink carbonated beverages other than cola drinks? If so, how many per day? Examples: Seltzer water, LaCroix, etc.

  [ ] 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 ever been diagnosed with hay fever? [ ] Yes [ ] No
- Do you ever been diagnosed with asthma? [ ] Yes [ ] No
- Do you use any nasal or oral inhalers? [ ] Yes [ ] No
- Have you ever been diagnosed with nasal polyps? [ ] Yes [ ] No
- Have you had multiple infections of the nose? [ ] Yes [ ] No
- Have you ever had recurrent sinus infections? [ ] 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 [ ] 1-5 [ ] 6-10 [ ] 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 use an electronic rechargeable toothbrush? [ ] Yes [ ] No
- Do you use a standard bristle toothbrush? [ ] Yes [ ] No
- 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

- Have you ever needed any dental caps/crowns? [ ] Yes [ ] No
  If so, how many? [ ] 1-2 [ ] 3-5 [ ] 6 or more
- Do you have any dentures? [ ] Yes [ ] No
- Do you have any dental bridges? [ ] Yes [ ] No
- How long do you take to brush her 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
- Have you had any root canals? [ ] Yes [ ] No

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

MEDICATION LIST

(PLEASE LIST *ALL MEDICATIONS* THAT YOU TAKE INCLUDING PRESCRIPTION MEDICATIONS, AS WELL AS VITAMINS, MINERALS, PAIN RELIEVERS, SUPPLEMENTS, AND PROBIOTICS)

MEDICATION	STRENGTH	# OF TIMES TAKEN DAILY
Example: Vitamin D	***1000 I.U.***	***Once***