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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	**[ ] 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:

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**

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?**
  [ ] 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
[ ] Probiotics
[ ] B12
[ ] Aspirin
[ ] Acid reducing medications
[ ] Multivitamin
[ ] Other over-the-counter supplements
[ ] 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
[ ] LSD
[ ] Cocaine
[ ] Methamphetamines
[ ] Methadone
[ ] 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 have any 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 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**
  If so, how many? [ ] 1-3 [ ] 4-6 [ ] 7-10 [ ] More than 10

- **Name of your dentist: _____**

  Address: _____

  City, State, ZIP Code: _____

  Telephone 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 current 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**

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***
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.		