Dyer GI Clinics of Illinois, L.L.C
Patient Health History Information

NAME: ____ SEX: F/ M BIRTHDATE: _____/_____/_____

PRIMARY CARE PHYSICIAN'S NAME: ____

PRIMARY CARE PHYSICIAN'S ADDRESS: ____

1) REASON FOR TODAY'S VISIT: ____

2) OTHER MEDICAL PROBLEMS: ____
____
____

3) **LIST ALL CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):**
____
____
____

4) **LIST ALL OVER-THE-COUNTER MEDICINES (including vitamins, and food supplements that you take):** ______
____
____

5) MEDICINE ALLERGIES: ______________________ 6) FOOD ALLERGIES: ______________________
____ ____
____ ____
____ ____

7) **Have you had (circle):** hepatitis mono ulcer bleeding problem
blood clots drug addiction gallstones tuberculosis STDs
arthritis psoriasis heart murmur rheumatic fever depression
mental illness hemorrhoids Any chronic skin disease Anal Itching Abdominal Pain
Radiation Therapy Chemotherapy Fecal incontinence (leakage)
Anal Pain (With or between bowel movements) Change in bowel habits
Bleeding on toilet paper, with bowel movement, or dripping

8) **Have you had (circle):** pelvic surgery Abdominal surgery Colon surgery Rectal surgery
Fibroid Tumors Prostate cancer Radiation therapy Chemotherapy Hysterectomy
Surgery for enlarged prostate (non- cancer) Tetanus Shot HIV test Hepatitis vaccine
Prostate Exam Colonoscopy

Family Health History

Please indicate members in your biological family that have or has had the following
(circle if cause of death and write age of death)

heart disease __________________________________ genetic disorder __________________________________
diabetes _______________________________________ cancer ____
thyroid disease ________________________________ alcoholism _______________________________________

mental illness ________________________________ arthritis ____

glaucoma ____________________________________ asthma ____

allergies ____________________________________ stomach problems ______________________________

tuberculosis __________________________________ high blood pressure ____________________________

Hepatitis ____________________________________ HIV/ AIDS _______________________________________

List any other medical conditions that run in your family and specify your relationship to each family member listed.

____

9) How much do you currently weigh? _______________________ Heaviest weight ___________________________

Do you EXERCISE? _______ How much? _______ hrs/wk Type of Exercise _____________________________

Do you SMOKE? _________ How much? _______ packs/day No. of years ________ Year you QUIT _________

Do you DRINK alcohol? _________ How much? _________ drinks/week No. of years _________

10) Do you have an artificial knee, hip, or any joint replacement?

____

11) Describe any chronic illnesses, including hepatitis or HIV/ AIDS.

____

12) Have you had any surgical procedure performed within the last 7 days?

____

13) Do you take any antibiotics before having your teeth cleaned?

____

14) Do you have a stent or artificial heart valve?

____

15) Are you on kidney dialysis?

____

16) Do you use (circle): Aspirin Plavix Coumadin

Is there any additional information that you'd like to share with the physician to assist in providing you service today?

____

____

____

PLEASE READ CAREFULLY

Your signature acknowledges that the information you are providing is accurate to the best of your abilities. Providing accurate information regarding you and your family's health history allows the physician to better assess your current health condition. Failure to provide accurate health history may result in you experiencing health complications and therefore exempts the Dyer GI Clinics of Illinois, L.L.C from liability when patient health history has not been presented to the physician prior to treating the patient.

Please sign and date: ____