Name: ________________________
DOB: ________________________
Date: ________________________

Health History Form: New Patient

Thank you for choosing our clinic for your healthcare needs! We appreciate your assistance with completing this form, as it will help us better care for you. This is confidential information to be kept in your electronic medical record. Please speak with your physician or nurse if you need assistance with this form.

Who is your referring physician? ____

Who is your primary care physician? ____

Who is your gastroenterologist? ____

What is the reason for your visit/most bothersome symptom?

____

What are your greatest worries and fears about your condition?

____

____

What is your Diagnosis?

__ Crohn's Disease
__ Microscopic colitis
__ Celiac disease
__ Ulcerative colitis
__ Pouchitis
__ Other: ___________________

Date of Diagnosis
___/___/______

Please complete if you have Crohn's Disease. **YESTERDAY**, how did you feel in terms of? General well-being: ☐ Very well ☐ slightly below par ☐ poor ☐ very poor ☐ terrible Abdominal pain: ☐ None ☐ mild ☐ moderate ☐ severe Number of liquid stools over past 24 hours: ___ Are you having any? ☐ Mouth ulcers ☐ Skin lesions ☐ Inflamed joints ☐ Anal sores ☐ Inflamed eyes	Please complete if you have ulcerative colitis. Answer on the basis of the **PAST 3 DAYS** On average, have many stools are you having daily? ☐ Normal ☐ 1-2 stools/day more than normal ☐ 3-4 stools/day more than normal ☐ 5 stools/day more than normal On average, how much rectal bleeding are you having? ☐ None ☐ Visible blood with stool less than half the time ☐ Visible blood with stool half of the time or more ☐ Passing blood alone

SF-12® QUALITY OF LIFE Patient Questionnaire

This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by placing a check mark on the line in front of the appropriate answer. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:
_____ Excellent (1)
_____ Very Good (2)
_____ Good (3)
_____ Fair (4)
_____ Poor (5)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:
_____ Yes, Limited A Lot (1)
_____ Yes, Limited A Little (2)
_____ No, Not Limited At All (3)

3. Climbing SEVERAL flights of stairs:
_____ Yes, Limited A Lot (1)
_____ Yes, Limited A Little (2)
_____ No, Not Limited At All (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:
_____ Yes (1)
_____ No (2)

5. Were limited in the KIND of work or other activities:
_____ Yes (1)
_____ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:
_____ Yes (1)
_____ No (2)

7. Didn't do work or other activities as CAREFULLY as usual:
_____ Yes (1)
_____ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?
_____ Not At All (1)
_____ A Little Bit (2)
_____ Moderately (3)
_____ Quite A Bit (4)
_____ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

10. Did you have a lot of energy?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

11. Have you felt downhearted and blue?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

12. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

Have you ever been treated with any of the following medications?

Medication			Medication		
Prednisone	☐ Yes	Dates:__________	Remicade	☐ Yes	Dates:__________
Mesalamine	☐ Yes	Dates:__________	Humira	☐ Yes	Dates:__________
Entocort	☐ Yes	Dates:__________	Cimzia	☐ Yes	Dates:__________
Uceris	☐ Yes	Dates:__________	Simponi	☐ Yes	Dates:__________
Enemas or Suppositories	☐ Yes	Dates:__________	Entyvio	☐ Yes	Dates:__________
Azathioprine (Imuran)	☐ Yes	Dates:__________	Stelara	☐ Yes	Dates:__________
Methotrexate	☐ Yes	Dates:__________	Xeljanz	☐ Yes	Dates:__________
Flagyl (Metronidazole)	☐ Yes	Dates:__________	TPN	☐ Yes	Dates:__________
Ciprofloxacin (Cipro)	☐ Yes	Dates:__________	Loperamide (Imodium)	☐ Yes	Dates:__________
Rifaximin	☐ Yes	Dates:__________	Diphenoxylate (Lomotil)	☐ Yes	Dates:__________
Pain Medication:	________________________		Experimental Drug:	________________________	
Probiotics:	________________________		Other medications:	________________________	

Medications Please list your CURRENT MEDICATIONS or attach a list of current medications: (Include herbal medications, dietary supplements, vitamins, Tylenol, Ibuprofen, injectables/infusions, and other over-the-counter medications)

Medication name	Dose and frequency

Pharmacy Name ________________________ Phone ___________________________

Address or Cross Street ___________________________ City ____________________________

Allergies (foods and drugs)

Please indicate the type of reaction next to each.

____

____

____

Past Medical History Problems (check all that apply and indicate date of diagnosis)

__ Melanoma	(Date: _____________)	__ Heart attack	(Date: _____________)
__ Other skin cancer	(Date: _____________)	__ Heart arrhythmia	(Date: _____________)
__ Broken bone(s)	(Date: _____________)	__ Heart failure	(Date: _____________)
__ Osteopenia	(Date: _____________)	__ Stroke	(Date: _____________)
__ Osteoporosis	(Date: _____________)	__ Emphysema/COPD	(Date: _____________)
__ Mononucleosis	(Date: _____________)	__ Asthma	(Date: _____________)
__ Chickenpox	(Date: _____________)	__ Pancreatitis	(Date: _____________)
__ Shingles	(Date: _____________)	__ Kidney Disease	(Date: _____________)
__ Abnormal Pap smear	(Date: _____________)	__ Tuberculosis	(Date: _____________)
__ Diabetes	(Date: _____________)	__ Depression	(Date: _____________)
__ High blood pressure	(Date: _____________)	__ Other psychiatric	(Date: _____________)
__ Multiple sclerosis	(Date: _____________)	__ Anemia	(Date: _____________)
__ Lupus	(Date: _____________)	__ Vitamin D deficiency	(Date: _____________)
__ Thyroid disease	(Date: _____________)	__ Vitamin B12 deficiency	(Date: _____________)

Please explain any items you checked and list any medical problems not included:
____
____

Past Surgical History

Please list all surgeries including dates.
____
____
____

Complications: (check all that apply and include the date of diagnosis)

Swollen or painful joints	(Date: _____________)	Primary sclerosing cholangitis	(Date: _____________)
Pain and stiffness in spine and hips	(Date: _____________)	Hepatitis, Type ☐ **A** ☐ **B** ☐ **C**	(Date: _____________)
		Other liver disease: ____________	(Date: _____________)
Joint pain without swollen joints	(Date: _____________)	Recurrent mouth sores	(Date: _____________)
		Perianal fistula	(Date: _____________)
Painful, red, skin rashes	(Date: _____________)	Perianal abscess	(Date: _____________)
Ulcerated skin sores	(Date: _____________)	Rectovaginal fistula	(Date: _____________)
Psoriasis	(Date: _____________)	Deep vein thrombosis	(Date: _____________)
Uveitis (eye pain)	(Date: _____________)	Pulmonary embolism	(Date: _____________)
Episcleritis (red eyes)	(Date: ____________)	Pneumonia	(Date: _____________)

Please list any complications not included: _______________________________________
____
____

Menstrual Status:

□ Regular □ Irregular □ Perimenopausal/Postmenopausal □ Hysterectomy

Last Menstrual Cycle (if applicable): ___/___/_____

Family Medical History

□ No knowledge of family history □ Adopted

Relation	Age	Medical Problems	If deceased, cause of death	Age of death
Father________________ Father's Father Father's Mother	_____ _____ _____	________________ ________________ ________________	______________________________ ______________________________	___________ ___________ ___________
Mother________________ Mother's Father Mother's Mother	_____ _____ _____	________________ ________________ ________________	______________________________ ______________________________ ______________________________	___________ ___________ ___________
Brother / Sister				
Brother / Sister				
Brother / Sister				
Other: _____________				

Diagnoses	Father	Mother	Brother	Sister	Grandfather	Grandmother	Other
Crohn's disease	□	□	□	□	□	□	□
Ulcerative colitis	□	□	□	□	□	□	□
Lymphoma	□	□	□	□	□	□	□
Colon cancer	□	□	□	□	□	□	□
Colon polyps	□	□	□	□	□	□	□
Celiac disease	□	□	□	□	□	□	□

Please list any other diseases that run in the family: ____

Social History

Marital Status:

☐ Single ☐ Married ☐ Divorced

How many children do you have? _________

Have you traveled outside the United States in the past two years?

☐ Yes, where? _________ ☐ No

Ashkenazi Jewish Ancestry:

☐ Yes ☐ No

Employment:

☐ retired ☐ unemployed ☐ employed
☐ disability ☐ homemaker ☐ student

What is your current/previous occupation?

____

Education:

☐ grade school ☐ some high school
☐ graduated high school ☐ GED ☐ some college
☐ graduated college ☐ post-graduate school

Have you ever been abused? □ No □ Physically □ Sexually □ Emotionally

Risk Factors

Tobacco/Smoking Status:

□ Current every day smoker
□ Former smoker
□ Never smoker
□ Current someday smoker

Start Date: ___________ Stop Date: ____________

How many cigarettes daily? __________

Alcohol: □ Never □ Former □ Socially □ Daily

How many drinks daily? _______

□ Beer □ Wine □ Liquor

Start Date: ___________ Stop Date: ____________

Recreational/street drugs:

□ Never □ Former □ Daily Type: _____________

<u>At the present time,</u> are you having any of the following symptoms:

General	□ fever □ night sweats □ fatigue	□ weight gain □ weight loss	**Joint**	□ pain □ stiffness
Head	□ eye pain □ eye redness	□ mouth sores	**Skin**	□ painful rashes □ skin ulcers
Chest	□ chronic cough □ shortness of breath	□ wheezing	**Vascular**	□ swelling in the feet □ calf pain with walking
Heart	□ palpitations □ chest pain with activity	□ chest pain at rest □ fainting	**Endocrine**	□ heat intolerance □ cold intolerance
GI	□ heartburn □ acid reflux □ pain with swallowing □ food sticking with swallowing □ abdominal pain □ abdominal distention □ fear of eating □ gurgling bowel sounds □ nausea □ vomiting □ loose stool □ rectal bleeding	□ urgent bowel movements □ false alarms of the rectum (urges to go but without producing any significant amount of stool) □ fear of passing stool (concern for leakage of stool) □ black stool □ anal pain □ pain around the anus □ swelling around the anus □ anal discharge □ jaundice □ itching □ milk intolerance	**Neurologic**	□ headaches □ weakness (face/extremities) □ numbness (face/extremities) □ problems with vision
			Women	□ irregular periods □ painful intercourse □ infertility □ passing stool or gas through the vagina
			Men	□ infertility □ erectile dysfunction
Genitourinary	□ kidney stones □ blood in urine □ stool in urine	□ pain/burning with urination □ frequent urination	**Psychiatric**	□ anxiety □ depression

Please list any health concerns, or any other items you would like to discuss with the doctor:

____

____

____

____

____

Preventative Care

Osteoporosis (bone thinning/weakening)

Have you ever had a bone density exam? □ Yes □ No

When: ___/___/_____

□ Normal □ Osteopenia □ Osteoporosis

Colon Cancer Screening

When was your last colonoscopy?
When: ___/___/_____
□ Normal □ Abnormal

Pap smears
Do you get annual Pap smears? □ Yes □ No

When was your last Pap smear: ___/___/___

Have you ever had an abnormal Pap smear?

When: ___/___/_____

Skin exam

Do you get annual skin exams?
□ Yes □ No

Immunizations

Are you worried about the **safety of vaccines?**
☐ Yes ☐ No

Are you worried about the **effectiveness of vaccines?**
☐ Yes ☐ No

Please list any other concerns about vaccines
____
____
____

When was your **last flu vaccine**? ____

Have you ever received a **pneumonia vaccine** (Pneumovax)? ☐ Yes, When? _________ ☐ No

Have you ever received a **Hepatitis A vaccine?**
☐ Yes, When? _________ ☐ No

Have you ever received a **Hepatitis B vaccine?**
☐ Yes, When? _________ ☐ No

Have you ever received a **Shingles vaccine?**
☐ Yes, When? _________ ☐ No

Have you ever had a **tuberculosis skin test?**
☐ Yes, When? _________ ☐ No
Result: ☐ Negative ☐ Positive

Have you ever had a **tuberculosis blood test?**
☐ Yes, When? _________ ☐ No
Result: ☐ Negative ☐ Positive