Baylor Scott & White
CENTER FOR ESOPHAGEAL DISEASES
A member of HealthTexas Provider Network

Patient Name: _____
Patient DOB: _____
Date: _____

Health History Questionaire

Who referred your consultation? _____

If no one referred you, how did you hear about us? _____

Who is your primary care physician? _____

Have you ever seen a gastroenterologist ? Please list their name(s).

- ☐ Yes, I am under the care of a gastroenterologist. _____
- ☐ Yes, I have seen one in the past, but not currently. _____
- ☐ No, I have never seen a gastroenterologist.

Please list your preferred pharmacy _____

What is your primary concern for today's visit? _____

Have you recently experienced any of the following? (Please check all that apply)

- ☐ Trouble Swallowing
- ☐ Food Gets Stuck
- ☐ Choking
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Regurgitation
- ☐ Belching

- ☐ Weight Loss
- ☐ Weight gain
- ☐ Change in appetite
- ☐ Feeling full early
- ☐ Sore Throat
- ☐ Voice Hoarseness
- ☐ Congestion
- ☐ Throat Clearing

- ☐ Abdominal Bloating
- ☐ Abdominal pain
- ☐ Recent change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black Tar-like stools
- ☐ Bleeding from rectum
- ☐ Vomiting Blood

- ☐ Fevers or chills
- ☐ Fatigue
- ☐ Headaches
- ☐ Dizziness
- ☐ Blurry Vision
- ☐ Double vision
- ☐ Hearing changes

- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Cough
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Yellowing of eyes or skin
- ☐ Skin rashes or lumps

- ☐ Heat or cold intolerance
- ☐ Trouble with urination
- ☐ Frequency of urination
- ☐ Joint pain or swelling
- ☐ Recent mood changes
- ☐ Memory changes
- ☐ Frequently anxious

Have you ever been treated for or had issues with any of the following? (Please check all that apply)

- □ Cancer : _____
- □ Hay fever
- □ Food allergies
- □ Heart Attack
- □ Irregular Heartbeat
- □ Valvular heart disease
- □ Congestive Heart Failure
- □ High blood pressure
- □ High cholesterol
- □ Pneumonia
- □ Asthma
- □ Empysema or Bronchitis
- □ Other lung disease
- □ Ulcers
- □ Chronic Diarrhea
- □ Colon Polyps
- □ Diverticulosis/Diverticulitis
- □ Irritable or spastic colon
- □ Colitis
- □ Gallstones
- □ Pancreatitis
- □ Hepatitis
- □ Other Liver Disease
- □ Genital Disorders
- □ Prostate Trouble
- □ Endometriosis
- □ Back/Spinal problems
- □ Kidney Stones
- □ Other Kidney Problems
- □ Goiter or thyoird trouble
- □ Diabetes
- □ Anemia (low blood count)
- □ Blood clot in lungs or legs
- □ Other blood disorders
- □ Poor Circulation
- □ Arthritis
- □ Stroke
- □ Seizures
- □ Depression or Anxiety

Have you every had the following operations? (Please check all that apply)

- □ Removal of gallbladder
- □ Fundoplication
- □ Antireflux surgery
- □ Hiatal hernia repair
- □ Gastric sleeve
- □ Gastric bypass
- □ Lap Band placement
- □ Myotomy for Achalasia
- □ Removalof stomach (part or all)
- □ Removal of appendix
- □ Hemorrhoid Surgery
- □ Removal of part/all of colon
- □ Removal of Spleen
- □ Heart Bypass
- □ Angioplasty
- □ Removal of Kidney
- □ Inguinal hernia repair
- □ Artificial blood vessel graft
- □ Replacement of Heart Valve
- □ Tonsillectomy
- □ Prostate surgery
- □ Hysterectomy
- □ Ovearies Removed
- □ Tubes tied
- □ Placement of artificial joint
- □ Eye Surgery
- □ Any other surgery on the esophagus or stomach

Have you every had the following procedures (Please check all that apply)

- □ Upper endoscopy (a lighted camera that goes into your mouth usually while you are sedated)
- □ Barium Swallow or Esophagram (You drink barium and are placed in different positions for X ray pictures)
- □ Esophageal motility study (a catheter that goes through your nose and you drink atleast 10 sips of salty water)
- □ Esophageal pH catheter based monitoring (a catheter that goes in your nose and monitors acid for 24 hours)
- □ Esophageal pH wireless monitoring (a caspsule attached to your esophageal lining to monitor acid)
- □ Colonoscopy

Please list any other medical conditions or operations:

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Please list any food or drug allergies and the reaction:

Please list all medications you currently take or provide your current medication list on another sheet:

Name, Dose, and Frequency of Medication:

Please circle yes or no for each of the following questions.

Are you on medications for diabetes?	Yes	No
Are you on steroids?	Yes	No
Are you on any blood thinners ?	Yes	No
Are you currently taking an acid suppression tablet regularly?	Yes	No
Have you ever been told you have a difficult airway or intubation?	Yes	No
Have you ever had a problem with anesthesia. Please explain.	Yes	No
Do you have sleep apnea or do you currently use a CPAP machine?	Yes	No

Family History

Please list any significant medical condition

Father: □ Alive □ Deceased Medical Problems/Cause of Death: _____

Mother: □ Alive □ Deceased Medical Problems/Cause of Death: _____

Number of Siblings: _____ _____ Sisters _____ Brothers

Number of Children: _____ _____ Sons _____ Daughters

Is there any family history of the following? Please list the family member.

Esophageal Cancer

Stomach Cancer

Colon Cancer

Eosinophillic Esophagitis

Celiac Disease

Liver Disease

Pancreatic Disease

Ulcerative Colitis

Crohn's Disease

Heart Disease

Diabetes

Breast Ovary Endometrial or Uterine Cancer

Other cancers

Social History

Please list your current marital status: _____

Who lives at home with you? _____

What is the highest level of education you have achieved?

☐ Some School ☐ Some College ☐ Masters or Doctorate Degree
☐ Highschool ☐ College Degree

In regards to school or work, check all that apply:

□ Working full time □ Stay at home parent / caregiver □ In School
□ Working part time □ Retired

What is your occupation / trade? _____

Tobacco

Have you used tobacco products?

□ Never smoked
□ Current user
□ Former user

Types of Tobacco used (check all that apply):

□ Cigarette □ Chewing products
□ Cigars □ Vapor

If you are a current tobacco user, how often do you use tobacco? _____

If you are a current tobacco user, how often do you use tobacco in a day? _____

If you are a former tobacco user, how long has it been since your last use? _____

How many years have you used tobacco? _____

Alcohol

Have you had a drink with alcohol in the past year? ☐ No ☐ Yes

If yes, How often have you had a drink containing alcohol in the past year?

☐ Never □ Monthly or Less □ 2 - 4 Times a month □ 2 - 3 Times a week □ 4 or More Times a Week

If yes, how many drinks did you have on a typical day when you were drinking? _____

If yes, please check all types of alcohol that was consumed:

□ Beer □ Wine □ Hard Liquor

Drugs

Do you smoke Marijuana? ☐ No ☐ Yes If so, how frequently? _____

Do you use any other illicit drugs? Please list: _____

Have you used any IV drugs (requring a needle)? Please list: _____

Do you have any tattoos? ☐ No ☐ Yes

Do you have any piercings? ☐ No ☐ Yes **Where?** _____

Signature: _____ **Date:** _____