IOWA DIGESTIVE DISEASE CENTER
GASTROENTEROLOGY, HEPATOLOGY, DIAGNOSTIC AND THERAPEUTIC ENDOSCOPY AND COLORECTAL SURGERY

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Patient History Questionnaire

To Be Completed by Patient Prior to Procedure. Please Print Clearly. Use Additional Paper, if Needed.

Patient Name: _____ **DOB:** _____
Primary Phone: _____ **Secondary Phone:** _____
Pharmacy: _____ **Name of Insured:** _____ **DOB:** _____
Insurance Name: _____ **Insurance ID#:** _____
Group Number: **PO Box:**

Allergies: (medications and food) (Attach additional allergy information using a separate sheet.)

Medication/Food/Other	Reaction	Medication/Food/Other	Reaction
Medication/Food/Other	**Reaction**	**Medication/Food/Other**	**Reaction**
Medication/Food/Other	**Reaction**	**Medication/Food/Other**	**Reaction**

Prescription and Non-Prescription Medications:

Please include Blood Thinners, Diabetes pills & insulin, and birth control. Also include your supplements and vitamins, Attach additional medication information using a separate sheet.

Medication Name	Dose	How Often	Medication Name	Dose	How Often

Surgeries: Attach additional surgery information using a separate sheet

Surgery	Date

General Questions: (Circle **Y**es or **N**o)

Do you use a cane, walker, or wheel chair?	Y	N
Do you have implanted medical devices?	Y	N
Do you require antibiotics before dental or invasive procedures?	Y	N
Are you allergic to latex?	Y	N
Are you pregnant or nursing a child?	Y	N
Do you have a family history of colon cancer?	Y	N
Can you have a competent adult driver with you during your procedure?	Y	N
Do you drink alcohol? **Y** **N** If Yes, how often? Daily, Weekly, Occasional		
Do you use recreational drugs? **Y** **N**. If yes, What Drugs: Marijuana? Meth?, Other? Please specify:		

Review of Systems

Do you now or have you had any problems related to the following systems? (Circle **Y**es or **N**o). Please explain any Yes answers in the space provided or below

Cardiovascular	**Yes**	**No**	**Explain**	**Gastrointestinal**	**Yes**	**No**	**Explain**
Irregular Heart Beat	Y	N		Abdominal Pain	Y	N	
Implanted Defibrillator	Y	N		Chronic Constipation	Y	N	
Pacemaker	Y	N		Chronic Diarrhea	Y	N	
History of Heart Attack	Y	N		Nausea and Vomiting	Y	N	
Pulmonary				**Neurological**			
COPD	Y	N		History of Seizures	Y	N	
Use CPAP Device	Y	N		Parkinson's Disease	Y	N	
Use of Oxygen at home	Y	N		History of strokes	Y	N	
Genitourinary				**Integumentary**			
Kidney Disease	Y	N		Chronic skin condition	Y	N	
Dialysis	Y	N		Shingles	Y	N	
Hematology				**Endocrine**			
Anemia	Y	N		Diabetes	Y	N	
Blood Clots	Y	N		Thyroid Disease	Y	N	
Abnormal Bleeding	Y	N					
Infectious Disease				**Other**			
Hepatitis	Y	N		Anesthesia Complications	Y	N	
HIV	Y	N		Malignant Hyperthermia	Y	N	
Tuberculosis	Y	N		TMJ (Temporomandibular joint disorder	Y	N	
MRSA	Y	N					

Height: _____ Weight:_____

Additional Information/Notes:
