

COLORECTAL SURGERY SERVICES, PLLC
Hemorrhoid Institute of South Texas

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Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name <i>(Last, First, M.I.):</i>	Date of Birth:
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Briefly describe your symptoms

List any medical problems that other doctors have diagnosed

List any past surgeries, colonoscopies or upper endoscopies		
Year	Reason	Hospital / Surgeon

Describe any other hospitalizations		
Year	Reason	Hospital / Physician

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List your prescribed drugs and over-the-counter drugs or give your list to the nurse		
Name the drug or food	Strength	Frequency Taken
Do you have any allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please include any over the counter or food allergies.		
Name the Drug	Reaction You Had	

Please answer the following questions and check all that apply.			
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your occupation?			

Please list any health problems in your family below.							
AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS	
Father			Children	<input type="checkbox"/> M			
				<input type="checkbox"/> F			
Mother			Siblings	<input type="checkbox"/> M			
				<input type="checkbox"/> F			
Siblings	<input type="checkbox"/> M		Grandmother <i>Maternal</i>	<input type="checkbox"/> M			
	<input type="checkbox"/> F			<input type="checkbox"/> F			
	<input type="checkbox"/> M			<input type="checkbox"/> M			
	<input type="checkbox"/> F			<input type="checkbox"/> F			
	<input type="checkbox"/> M			<input type="checkbox"/> M			
	<input type="checkbox"/> F			<input type="checkbox"/> F			
	<input type="checkbox"/> M			<input type="checkbox"/> M			
	<input type="checkbox"/> F			<input type="checkbox"/> F			
			Grandmother <i>Paternal</i>				
			Grandfather <i>Maternal</i>				
			Grandmother <i>Paternal</i>				
			Grandfather <i>Paternal</i>				

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Do you have any of the following symptoms? Check the box "yes" or "no" to the right.		
Eyes	Visual problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Discharge from eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ears, nose & throat	Mouth sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart and blood vessels	Recurrent chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Discomfort breathing by lying flat	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Swelling of the legs or feet	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Pain in legs or feet when walking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lungs	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Chronic cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Chronic sputum	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal tract	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Heartburn or indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Bleeding from rectum	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Nausea or vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Bloating	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Rectal or anal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urinary system	Stool or gas in urine stream	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Difficulty passing urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Leakage of urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Pain or burning on urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscles and bones	Limitation of motion	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Muscular weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Muscle cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Joint or bone pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin and breast	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Skin itching	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Breast mass	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Nipple discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brain and nerves	Recurrent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Tingling in extremities	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Convulsions or seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Fainting or syncope	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Do you have any of the following symptoms? Check the box "yes" or "no" to the right.		
Psychiatry	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Panic episodes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine and glands	Cold intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Heat intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Tremors	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Excessive sweating	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Excessive urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Excessive thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood and immune system	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Easy bruising or bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Excess bleeding with dental work	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Swollen glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
	HIV positive or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Allergy to shellfish or iodine	<input type="checkbox"/> Yes <input type="checkbox"/> No
General Health	Fevers or chills	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Poor appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Chronic tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No

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You may fill this form out in the office or fill it out at home and bring it with you.

You can also fax this form to the office 2 days prior to your appointment date.

Fax number (210) 490 - 0505