Health History

Please answer these questions concerning your health status. This information will help Dr. Roseman take better care of you. Of course, all information is confidential

Name _____ Age _____ Date of Birth _____

What is the main reason for today's visit? _____

Family Doctor's Name _____

Health Habits

Please answer each question by checking the appropriate box.

Do you…

☐ Yes ☐ No Currently smoke cigarettes?
_____packs per day_____

☐ Former Smoker ☐ Never a smoker

☐ Yes ☐ No Chew tobacco?
How much? _____

☐ Yes ☐ No Drink beer?
_____bottles per _____

☐ Yes ☐ No Drink wine?
_____oz. per _____

☐ Yes ☐ No Drink hard liquor?
_____oz. per _____

☐ Yes ☐ No Use aspirin, ibuprofen, 'arthritis medications'
How often? _____

☐ Yes ☐ No Drink beverages with caffeine
_____ cups per day

☐ Yes ☐ No On a special diet
What type? _____

☐ Yes ☐ No Do you exercise LESS than twice a week?

Operations

☐ NONE

What was done? **About when?**

_____

_____

_____

Current Medications and Dose

☐ NONE

(Include all non-prescription medications)

Drug	**Strength**	**How Often**

Allergies to Medications

☐ NONE

_____

_____

_____

_____

Do you have a Latex allergy? ☐ Yes ☐ No
Do you use oxygen? ☐ Yes ☐ No
Do you have a defibrillator? ☐ Yes ☐ No

Family Health History

Do these problems run in your family? Please mark an "X" where appropriate.

	Father	**Mother**	**Father's Father**	**Father's Mother**	**Mother's Father**	**Mother's Mother**	**Brothers**	**Sisters**	**Other**
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcer Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gallbladder Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcerative Colitis/ Crohn's	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Sprue	☐	☐	☐	☐	☐	☐	☐	☐	☐

06/2016

HERITAGE VALLEY MEDICAL GROUP

Sharon R. Roseman, MD, FACP
Practice Limited to Gastroenterology

Name:_____Date of Birth:_____

Review of Systems

Sharon R. Roseman, MD, FACP
Practice Limited to Gastroenterology

Please check the boxes (yes or no) for each condition mentioned below…

General

- ☐ Y ☐ N Unexpected weight loss
- ☐ Y ☐ N Recent weight gain
- ☐ Y ☐ N Fever or shaking chills
- ☐ Y ☐ N Night sweats
- ☐ Y ☐ N Swollen glands
- ☐ Y ☐ N Take Coumadin, Blood-thinners

Skin

- ☐ Y ☐ N Severe itching
- ☐ Y ☐ N Persistent rash
- ☐ Y ☐ N Changing moles
- ☐ Y ☐ N Psoriasis

Head

- ☐ Y ☐ N Severe headaches
- ☐ Y ☐ N Double vision
- ☐ Y ☐ N Glaucoma
- ☐ Y ☐ N Cataracts
- ☐ Y ☐ N Difficulty hearing
- ☐ Y ☐ N Ringing in ears
- ☐ Y ☐ N Wear hearing aid
- ☐ Y ☐ N Wear dentures
- ☐ Y ☐ N Loose teeth
- ☐ Y ☐ N Bleeding gums
- ☐ Y ☐ N Severe nosebleeds
- ☐ Y ☐ N Frequent sore throats
- ☐ Y ☐ N Persistent hoarseness

Blood

- ☐ Y ☐ N Blood transfusion in past 6 months
- ☐ Y ☐ N Prolonged bleeding from surgery
- ☐ Y ☐ N Anemic in past
- ☐ Y ☐ N Ever treated for cancer
- ☐ Y ☐ N Think I am at high risk for AIDS

Muscles and Joints

- ☐ Y ☐ N Muscle cramps
- ☐ Y ☐ N Muscle weakness
- ☐ Y ☐ N Arthritis or joint pain
- ☐ Y ☐ N Frequent back pain

Endocrine

- ☐ Y ☐ N Thyroid problem
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Take insulin

Heart and Lungs

- ☐ Y ☐ N High blood pressure
- ☐ Y ☐ N High cholesterol
- ☐ Y ☐ N Heart disease
- ☐ Y ☐ N Heart attack in past
- ☐ Y ☐ N Fainting spells
- ☐ Y ☐ N Irregular heartbeat
- ☐ Y ☐ N Wear pacemaker
- ☐ Y ☐ N Have a defibrillator
- ☐ Y ☐ N Chest pain
- ☐ Y ☐ N Sleep apnea
- ☐ Y ☐ N Shortness of breath
- ☐ Y ☐ N Use oxygen
- ☐ Y ☐ N Can't breathe when lying flat
- ☐ Y ☐ N Awaken short of breath
- ☐ Y ☐ N Ankle swelling
- ☐ Y ☐ N Heart murmur
- ☐ Y ☐ N Mitral valve prolapse
- ☐ Y ☐ N Artificial valve
- ☐ Y ☐ N Frequent cough
- ☐ Y ☐ N Cough up sputum
- ☐ Y ☐ N Cough up blood
- ☐ Y ☐ N Wheezing or asthma
- ☐ Y ☐ N Rheumatic fever as child

Digestive Tract

- ☐ Y ☐ N Poor appetite
- ☐ Y ☐ N Nausea
- ☐ Y ☐ N Vomiting
- ☐ Y ☐ N Frequent heartburn
- ☐ Y ☐ N Heartburn awakens
- ☐ Y ☐ N Trouble swallowing
- ☐ Y ☐ N Hiatal hernia in past
- ☐ Y ☐ N Rectal bleeding
- ☐ Y ☐ N Rectal pain
- ☐ Y ☐ N Black bowel movements
- ☐ Y ☐ N Vomited blood
- ☐ Y ☐ N Ulcers in past
- ☐ Y ☐ N Abdominal pain
- ☐ Y ☐ N Diarrhea
- ☐ Y ☐ N Lost bowel movement/soiling
- ☐ Y ☐ N Constipation
- ☐ Y ☐ N Bowel habit unpredictable
- ☐ Y ☐ N Milk or lactose intolerance
- ☐ Y ☐ N Colon polyps in past
- ☐ Y ☐ N Colon cancer in past
- ☐ Y ☐ N Liver disease or jaundice
- ☐ Y ☐ N Gallstones

Kidneys

- ☐ Y ☐ N Kidney stones
- ☐ Y ☐ N Kidney disease
- ☐ Y ☐ N Frequent urination
- ☐ Y ☐ N Up nights to urinate
- ☐ Y ☐ N Blood in urine
- ☐ Y ☐ N Painful urination
- ☐ Y ☐ N Slow urination
- ☐ Y ☐ N Leakage of urine

Brain

- ☐ Y ☐ N Epilepsy or seizures
- ☐ Y ☐ N Past strokes

Emotions

- ☐ Y ☐ N Often depressed
- ☐ Y ☐ N Cry easily
- ☐ Y ☐ N Overly anxious
- ☐ Y ☐ N Can't handle stress

Men only

- ☐ Y ☐ N Lump in testicles
- ☐ Y ☐ N Penis discharge
- ☐ Y ☐ N Erection difficulties

Women only

- ☐ Y ☐ N Pregnant now
- ☐ Y ☐ N Planning pregnancy
- ☐ Y ☐ N Nipple discharge
- ☐ Y ☐ N Lump in breast
- ☐ Y ☐ N Vaginal discharge
- ☐ Y ☐ N Hot flashes
- ☐ Y ☐ N Non-period bleeding
- ☐ Y ☐ N Past menopause
- ☐ Y ☐ N Painful intercourse
- ☐ Y ☐ N Change in periods
- ☐ Y ☐ N Past endometriosis

Other Condition(s):

_____

_____

Thank you for completing this questionnaire

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