

Patient Health Survey
Strictly Confidential

Today's Date: _____

Name: _____

**6. Circle YES or NO for the following
FAMILY HISTORY:**

Colitis	Y	N
Colon cancer	Y	N
Cancer	Y	N
Colon polyps	Y	N
Crohn's disease	Y	N
Celiac disease	Y	N
Liver disease	Y	N
Pancreas disease	Y	N

Father: _____

Mother: _____

Other: _____

**7. Circle YES or NO for the following
HABITS AND SOCIAL HISTORY:**

Drink coffee	Y	N
Smoke tobacco	Y	N
Formerly smoked	Y	N
Chew tobacco	Y	N
History of IV drug use	Y	N
Drink alcohol now	Y	N
Formerly drank alcohol	Y	N

Number of alcohol drinks
each week? _____

Marital status? _____

Who lives with you? _____

Occupation: _____

**8. Circle YES or NO for the following
SYMPTOMS:**

Poor appetite	Y	N
Fevers	Y	N
Weight loss	Y	N
Fatigue	Y	N
Glaucoma	Y	N
Hearing problems	Y	N
Dentures	Y	N
Sleep apnea	Y	N
Short of breathe	Y	N
Cough	Y	N
Coughing blood	Y	N
Chest pain	Y	N
Palpations	Y	N
Blood in urine	Y	N
Painful urination	Y	N
Urinary leakage	Y	N
Joint pain	Y	N
Anesthesia trouble	Y	N
Easy bruising	Y	N
Abnormal lumps	Y	N
Insomnia	Y	N
Depression	Y	N

Other: _____

THANK YOU!

*Information provided by patient on these
forms (page 1 and 2) were reviewed.*

Physician

Initials: _____

Date: _____