TRI CITIES DIGESTIVE HEALTH CENTER

Mid-Columbia Endoscopy Center, LLC
8819 W. Victoria Ave.
Kennewick, WA 99336

Today's Date:	
Appointment Date:	
Appointment Time:	

(509) 460-5500 appointment line
(509) 460-5111 fax line
(509) 460-4788 business line

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**		
Previous or referring doctor:		**Date of last physical exam:**			
Reason for your appointment:					
Date of last colonoscopy:		**Doctor's Name:**			

PERSONAL HEALTH HISTORY

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency Taken

Allergies to medications

Drug Name	Reaction You Had

List any medical problems with the date diagnosed.

Medical Problem	Date

Please see reverse side

List any surgeries you may have had		
Year	Surgery	Hospital
Other hospitalizations		
Year	Reason	Hospital

FAMILY HEALTH HISTORY							
	AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS
Father				***Children***	☐ M ☐ F		
Mother					☐ M ☐ F		
Sibling	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			**Grandmother** *Maternal*			
	☐ M ☐ F			**Grandfather** *Maternal*			
	☐ M ☐ F			**Grandmother** *Paternal*			
	☐ M ☐ F			**Grandfather** *Paternal*			

SOCIAL HISTORY				
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Number of Children:		**Occupation:**		
Smoking:	☐ Yes ☐ No	**If yes, Number of cigarettes/packs per day:**		**If you have quit, year quit:**
Alcohol:	☐ Yes ☐ No	**If yes, amount and frequency of drinks:**		

Please return your completed questionnaire as soon as possible. We would like to update and prepare your medical history in your record before you come in for your upcoming appointment to make your appointment time more efficient.

Thank you!