DIGESTIVE DISEASE & NUTRITION
CENTER OF WESTCHESTER, LLP
Excellence in Gastroenterology and Nutrition for over 25 years

Today's Date: _____

Name (First, Last, MI): _____ □ M □ F DOB: _____
Previous/Referring Physician: _____ Date of Last Exam: _____

Reason for today's visit: _____
_____

PERSONAL HISTORY

Childhood Illnesses: □ Measles □ Mumps □ Rubella □ Chicken Pox □ Rheumatic Fever □ Polio
Immunizations & dates: □ Tetanus _____ □ Hepatitis _____ □ Influenza _____ □ Hepatitis _____
List any medical problems that other doctors have diagnosed:

List any surgeries or hospitalizations

Year	Reason	Hospital

Blood Transfusion: Have you ever had any blood transfusions: □ YES □ NO

Allergies: Do you have any allergies to:
Drugs: □ Yes □ No - (List if yes): _____
Foods: □ Yes □ No - (List) if yes: _____
Chemicals: □ Yes □ No - (List) if yes: _____

HEALTH HABITS AND PERSONAL SAFETY

Exercise:
□ Sedentary
□ Mild exercise (e.g. climbs stairs, walk three blocks, golf etc)
□ Occasional vigorous exercise (Work or recreation, less than less than 4 x per week for less than 30 min.)
□ Regular vigorous exercise (Work or recreation, 4 x per week for less than 30 min or more.)

Dieting? Are you on a diet? □ YES □ NO
If yes what program are you on? _____

Fat Intake □ High □ Medium □ low

Caffeine: □ None □ Coffee □ Tea □ Cola **Number of cups a day:** _____

Alcohol: Do you drink alcohol? □ YES □ NO
Frequency: □ Daily □ weekly □ occasionally □ socially
How many drinks per week: _____

Tobacco: Do you use tobacco □ YES □ NO
□ Smoke # of years: _____ packs a day: _____ Pipe # per day: _____ Cigar # per day: _____
Quit: □ YES (Years: _____) □ NO - If smoking, considering quitting: □ YES □ NO
□ chew - # of times a day: _____ Quit: □ YES □ NO - considering quitting: □ YES □ NO

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