

**Health Information Questionnaire**  
**Gastroenterology and Hepatology**  
**Dordaneh Maleki, MD, FACP**

Revised 12/29/2015

Name: \_\_\_\_\_

Date: \_\_\_\_\_

❖ List all Health Conditions that you currently have or have had in the past:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

❖ List all Surgeries and Procedures that you have had:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

❖ What Medications *with dosage* are you currently taking?

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

❖ Do you have any allergies to any medications, shellfish or iodine? \_\_\_\_\_

❖ Do you smoke cigarettes, cigars, or pipes? How about in the past? How many and for how long?  
\_\_\_\_\_

❖ Do you drink alcohol? How about in the past? How much and for how long?  
\_\_\_\_\_

❖ Do you take illegal drugs? How about in the past? If so, for how long?  
\_\_\_\_\_

❖ Is there any history of cancer in your family?

- What kind? Who and what is their relationship to you?

\_\_\_\_\_  
\_\_\_\_\_

❖ Is there any medical condition that runs in your family?

- What kind? Who and what is their relationship to you?

\_\_\_\_\_  
\_\_\_\_\_

❖ Do you have any cultural/language/visual/hearing or religious factors that may affect your medical care?  
\_\_\_\_\_

❖ Do you have a living will? Yes \_\_\_ No \_\_\_ Did you receive a copy of the privacy act? Yes \_\_\_ No \_\_\_

Patient Signature \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed and signed by: Dr. Dordaneh Maleki

\_\_\_\_\_  
*Physician Signature*

Dated: \_\_\_\_\_