

GASTROENTEROLOGY NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Date: _____

Print Patient Name: _____ **Date of Birth:** _____

Last _____ First _____ MI _____ Gender: Male Female
 Married/Partner: Yes No
 Children: Yes No

Address: _____ **Home Phone #:** _____ (mark preferred # with an *)
 _____ **Cell Phone #:** _____
 _____ **Work Phone #:** _____

Email: _____ **Contact Phone #:** _____

Emergency Contact Name: _____ **Relationship to Patient:** _____

Occupation: _____
Referred By: _____
State Reason for your visit to the Gastroenterologist: _____

HISTORY OF GASTROINTESTINAL ILLNESS

(Mark any you have had or currently have)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Nausea | <input type="checkbox"/> Duodenal Ulcer | <input type="checkbox"/> Black Stools |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Bloating | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Belching | <input type="checkbox"/> Regurgitation | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Gas | <input type="checkbox"/> Food Intolerance | <input type="checkbox"/> Gastritis |

REVIEW OF SYSTEMS

(Mark any you CURRENTLY have)

- | | | | |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Unintentional Weight Loss | <input type="checkbox"/> Eye Inflammation | <input type="checkbox"/> Mouth Lesions | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Skin Lesions | <input type="checkbox"/> Burning on Urination | | |

Print Patient Name: _____ Last _____ First _____ MI _____ Date of Birth: _____

PREVIOUS GASTROINTESTINAL TEST

(Give dates of any of the following test you have had)

Hemoccult Cards: _____ Flexible Sigmoidoscopy: _____
Colonoscopy: _____ Upper Endoscopy (EGD): _____
Barium Enema: _____ Upper GI Series (X-ray): _____
Abdominal Sonogram: _____ Pelvic Sonogram: _____
CAT Scan: _____ Other: _____

FAMILY HISTORY OF GASTROINTESTINAL ILLNESS

(Indicate any illness your relatives have had and list which relative)

Colon Cancer: _____ Diverticulitis: _____
Colon Polyps: _____ Liver Disease: _____
Colitis: _____ Hepatitis: _____
Crohn's Disease: _____ Pancreatic Disease: _____
Peptic & Stomach Ulcers: _____ Other: _____
Gallbladder Disease: _____

PAST MEDICAL HISTORY

(Please list any conditions such as diabetes, high blood pressure, heart disease, etc.)

(Please list any surgeries or hospitalizations – include the year)

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MEDICATIONS

(Please list any medications (prescription and over the counter) that you are currently taking)

DRUG ALLERGIES

DO YOU SMOKE? NO YES FORMERLY Maximum packs per day _____ Number of Years _____ When Quit _____

DO YOU DRINK ALCOHOL? NO YES If yes, how many drinks per week? _____

HOW WOULD YOU LIKE TO BE CONTACTED WITH TEST RESULTS, LAB RESULTS, ETC?

Telephone #: _____ May we leave a message on a machine? YES NO
May we leave a message with a spouse or relative? YES NO

Email address: _____ YES NO

Patient Signature: _____ Date: _____
OR
Guardian Signature: _____ Date: _____

Physician Signature/ Date: _____