Patient Questionnaire

Name_________________________________ **Age** ______ **Date** ______________

Referred by:____

Major Problem (Briefly state the primary reason you are here today):

Do you have any other problems or concerns?

Recent Symptoms (check all that apply)

☐ Abdominal pain
☐ Heartburn
☐ Nausea/Vomiting
☐ Difficulty swallowing
☐ Chest pain
☐ Change in bowel habits
☐ Diarrhea/Constipation (circle one or both)
☐ Blood in stools
☐ Hemorrhoids
☐ Gas/bloating

Past Gastrointestinal History

☐ Ulcers
☐ Colon polyps
☐ Irritable Bowel Syndrome (IBS)
☐ Heartburn or acid reflux
☐ Crohn's Disease
☐ Ulcerative Colitis
☐ Liver disease or hepatitis
☐ Diverticulosis
☐ Prior colonoscopy or upper endoscopy/EGD? (Circle one or both)
When?____

Please list all **medications** (prescription or over-the-counter), **vitamins, herbal preparations** that you are currently taking.

Medication/supplement	Dose	Frequency
_______________	_______	_______________
_______________	_______	_______________
_______________	_______	_______________
_______________	_______	_______________
_______________	_______	_______________
_______________	_______	_______________
_______________	_______	_______________
_______________	_______	_______________

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Medication allergies: ____

Previous surgical history (please include year)

☐ Gallbladder/cholecystectomy____________ ☐ Appendix/appendectomy_____________
☐ Heart surgery________________________ ☐ Hysterectomy- ovaries in/out (circle)____
☐ Bowel/Colon surgery__________________ ☐ Stomach surgery_____________________
☐ Other surgery____

Past Medical History

☐ Heart Disease________________________ ☐ Anemia____________________________
☐ High blood pressure/Hypertension_______ ☐ Cancer of ___________________________
☐ Lung disease_________________________ ☐ Kidney disease_____________________
☐ Thyroid disease______________________ ☐ Depression/anxiety (circle one or both)
☐ Diabetes____________________________ ☐ Other______________________________

Family History

Father: ☐ Alive Age: _____ ☐ Deceased Age: _____ Cause of death:______________
Mother: ☐ Alive Age: _____ ☐ Deceased Age: _____ Cause of death:______________

Do you have any relatives with the following health conditions?

☐ Colon polyps ☐ Who? ______________ Age at onset________________
☐ Celiac sprue ☐ Who? ______________ Age at onset________________
☐ Crohn's or ulcerative colitis ☐ Who? ______________ Age at onset________________
☐ IBS (Irritable Bowel Syndrome) ☐ Who? ______________ Age at onset________________
☐ Liver disease ☐ Who? ______________ Age at onset________________
☐ Diabetes ☐ Who? ______________ Age at onset________________
☐ Pancreatitis ☐ Who? ______________ Age at onset________________
☐ Gallstones ☐ Who? ______________ Age at onset________________
☐ Colon cancer* ☐ Who? ______________ Age at onset________________
☐ Ovarian or endometrial cancer* ☐ Who? ______________ Age at onset________________
☐ Pancreatic cancer* ☐ Who? ______________ Age at onset________________
☐ Gastric/stomach cancer* ☐ Who? ______________ Age at onset________________
☐ Other cancer (type____________) ☐ Who? ______________ Age at onset________________

Social History/Habits

Marital status: (circle one) **S**ingle **M**arried **D**ivorced **W**idowed **O**ther

Occupation:____________________________ Number of Children________________________

Smoking: ☐ Yes (How much?__________) ☐ Never ☐ Quit (When?________)
Alcohol: ☐ Yes (How much?__________) ☐ Never ☐ Quit (When?________)