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Digestive Care Patient Questionnaire

Patient Name:___________________________ Date:___________________

It is very important that your physician has current and accurate information in order for him to provide you with the best medical care available. Please take your time in answering the following questions.

Requesting Physician:____

Primary Care Physician:____

My Chief Complaint is:____

I was referred here for:____

Present Medications/ Dose Please List ALL	**ALLERGIES**

Have you been on Steroids/ 6MP or Azathiprine ? If so how long and how much

Have you ever been on Remicade,Humira or Cimzia? If so which med ,when and how long did you take the medication____

____

Indicate if you have had *any* of the following GI Procedures and approximate date (months/years ago) --and findings, if known.

Exam	**Exam Date**	**Findings:**
☐ **Colonoscopy**		
☐ EGD (Endoscopy)		
☐ Capsule Endoscopy		
☐ ERCP		
☐ CT SCAN		
☐ Ultrasound		
☐ UGI Series		
☐ Small Bowel Series		
☐ Barium Enema		
☐ MRI		
☐ **Other:**		
☐ Other:		

Indicate if ***you*** **presently have** or **have been treated** for *any* of the following gastrointestinal conditions

☐ Barrett's Esophagus	☐ Gastritis
☐ Upper GI Bleeding	☐ Gallbladder Disease
☐ Rectal Bleeding	☐ Hepatitis Type
☐ Colon Polyps	☐ Hiatal Hernia
☐ **Colon Cancer When?**	☐ Irritable Bowel Syndrome
☐ Constipation	☐ Liver Disease
☐ **Crohn's Disease Location__________**	☐ Ulcer Disease (Gastric or Peptic)
☐ Diverticulosis	☐ **Ulcerative Colitis**
☐ Esophageal Reflux	**OTHER**

Indicate if you **presently have** or **have been treated** for *any* of the following general medical conditions **Please be Specific**

☐ Anemia	☐ Diabetes Mellitus
☐ Asthma	☐ HIV
☐ Atrial Fibrillation	☐ Hyperlipidemia
☐ **Cancer TYPE/Location**	☐ Hypertension
	☐ Kidney Disease
☐ COPD	☐ Neurologic Disorders
☐ Congestive Heart Failure	☐ Thyroid Disorders
☐ Coronary Artery Disease/Heart Attack	☐ Valvular Heart Disease

ALL OTHER Med Conditions

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____

Indicate if you **have had any** of the following surgeries and approximate date

Surgery	Date	Surgery	Date
☐ Appendectomy		☐ Coronary Artery Bypass Graft	
☐ Biliary Surgery		☐ Heart Valve Replacement	
☐ Fistula Surgery		☐ Hernia Repair	
☐ Colon Polyps		☐ Inguinal Hernia Repair	
☐ Colon Resection Partial		☐ Pacemaker Placement	
☐ Hemorrhoidectomy		☐ Ovaries removed	
☐ Gastric Surgery		☐ Tonsils-Adenoids	
☐ Small Bowel Resection		☐ TURP	
☐ Ulcer Surgery		☐ Prostate Radiation seeds	
☐ Gastric Bypass		☐ Gastric Lap Band	
☐ Gall Bladder Removal		☐ Other:	

Indicate if anyone in your **immediate family** has had any of the following diseases

Diagnosis	Relationship	Diagnosis	Relationship
Breast Cancer		Diabetes	
Colon Cancer		Early Death	
Colon Polyps		Heart Disease	
Ovarian Cancer		Hepatitis	
Prostate Cancer		Hypertension	
Cancer - Other		Liver Disease	
Depression		Thyroid Disorder	

Social Information & History

Occupation:	____			
Current Status:	☐ Single	☐ Married	☐ Widowed	☐ Divorced
Alcohol Use:	☐ Yes ☐No	If yes, frequency: ______________	How much: ______________	
Caffeine Use	☐ Yes ☐No	If yes, frequency: ______________	How much: ______________	
Smoking	☐ Yes ☐No	_ packs / day -----cigarettes / day	When did you quit?	
Recreational Drug Use	☐ Yes ☐No			
Influenza Vacc	When_______	**PNEUMOVAX Vaccine**	When_______	
Exercise Habits	How often?	______________	What type?	______________

Indicate if you presently have or are being treated for any of the following symptoms:

General
Chills ______
Fever ______
Night Sweats ______
Feeling tired or poorly (malaise) ______
Other (weight gain / loss)

Head Symptoms
Headache ______
Facial pain ______
Sinus pain ______
Other head symptoms ______

Eye Symptoms ______
Worsening vision ______
Blurred vision ______
Vision distortion ______
Other eye symptoms

Otolaryngeal Symptoms
Earache ______
Nosebleeds (epistaxis) ______
Nasal discharge ______
Mouth sores ______
Bleeding gums ______
Hoarseness ______
Throat pain

Neck Symptoms
Neck pain ______
Neck stiffness ______
Lump or swelling in neck area ______
Other neck symptoms

Cardiovascular symptoms
Chest pain or discomfort ______
Fast heart rate ______
Palpitations ______
Other cardiovascular symptoms ______
______

Pulmonary Symptoms
Shortness of breath ______
Cough ______
Coughing up blood (hemoptysis) ______
Wheezing ______
Other Pulmonary symptoms ______

Genitourinary Symptoms
Dysuria-burning, difficulty urinating ______
Increased urinary frequency ______
Hematuria (blood in urine) ______
Other: ______

Female (GYN)
Vaginal bleeding ______
Vaginal discharge ______
Vaginal pain during intercourse ______
______

Skin Symptoms ______
Pruritus (itching) ______
Skin lesions ______
Rashes ______
Other skin symptoms:

Stool Description if abnormal
Change in stool color ______
Change in stool character ______
Size of the stool has changed ______
Consistence of the stool has changed ______
Foul smelling ______
Diarrhea ______
Other GI symptoms

Musculoskeletal Symptoms
Joint pain, localized ______
Joint stiffness, localized ______
Muscle aches ______
Low back pain

Neurological Symptoms
Dizziness ______
Vertigo ______
Fainting (syncope) ______
Motor disturbances ______
Sensory disturbances ______

Psychological Symptoms
Sleep disturbances ______
Anxiety ______
Depression ______
Other psychological symptoms: ______

None of the above apply to me ________ Signature____________________ DATE_______