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Patient Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Primary Doctor: _____

Reason for Visit: _____

Height _____ Weight_____

Have you had recent Blood Tests or X-Rays: ❑ Yes ❑ No Where: _____

Describe the Present Symptoms: _____

_____

Past Medical Problems: (circle all that apply):

Hypertension	Stroke	COPD	Schizophrenia
Hypothyroid	Hyperlipidemia	Heartburn	Cancer
Diabetes insulin	Arthritis	Depression	Joint replacement
Diabetes noninsulin	Asthma	Bipolar	Skin Cancer
Heart Attack	Rheumatoid	Anxiety	
Atrial Fibrillation	Arthritis	Bipolar	

Other:_____

_____

Operations: ❑NONE

Reason:	Approximate Date:
_____	_____
_____	_____

ENDOSCOPY: ❑NONE

COLONOSCOPY DATE_____ WHERE_____

FINDINGS _____

EGD DATE _____ WHERE_____

FINDINGS _____

Medications and Dosage (Please also include non-prescription medications):

Name of Drug:	Dosage:	Times per Day:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication or Latex Allergies:

_____

_____

Have you or any of your family members had problems with anesthesia ❑ Yes ❑ No

Do you take: ❑ aspirin? ❑ ibuprofen (Motrin)? ❑ naproxen (Aleve)? Amount: _____

How often? _____ Do these medications upset your stomach? ❑ Yes ❑ No

Your Family History:

	Age	Deceased?	Significant illnesses and/or Cause of death
Mother	___	❑	_____
Father	___	❑	_____
Brothers	___	❑	_____
	___	❑	_____
Sisters	___	❑	_____
	___	❑	_____

Children: Ages, Health Problems: _____

Other Medical Conditions in Your Immediate Family: ❑ Diabetes ❑ Cancer ❑ Colitis ❑ Heart Disease ❑ Liver Disease ❑ Other: _____

Occupation (or former occupation if retired): _____

Do you smoke? ❑Yes ❑No ❑Former How long? _____ Cigarettes per day:_____

Do you drink alcohol? ❑Yes ❑No ❑Former Type: _____ Drinks per week: _____

Do you drink coffee? ❑Yes ❑ No How many cups per day? _____

Do you drink milk or take other milk products? ❑Yes ❑ No How much? _____

Do you have an advance directive? ❑ Yes ❑ No

Do you have any religious of cultural beliefs we should be aware of? ❑ Yes ❑ No

Please **CIRCLE** all that apply.

General Health:

Unexpected weight loss
Loss of appetite
Unusual recent life stresses

Eyes/Ears/Throat:

History of glaucoma
Chronic sore throat
Ear infections

Heart:

Chest pain or angina
Irregular heart beat
Heart attack or heart failure
Heart murmur or valve disease

Lungs:

Shortness of breath
Asthma or wheezing
Emphysema or chronic bronchitis
Pneumonia
Sleep Apnea

Gastrointestinal and Liver:

Difficult or painful swallowing
Heartburn or acid reflux
Nausea or vomiting
Abdominal pain
Vomiting blood
Gallstones
Pancreatitis
Hepatitis (type, if known)
Abnormal liver tests
Blood transfusions
Intravenous drugs/other needle exposure
Frequent episodes of diarrhea
Intestinal infections or colitis
Chronic constipation
Blood with bowel movements
Black or tarry bowel movements
History of colon polyps

Urinary/Reproductive:

Frequent urine infections
Blood in the urine
Kidney stones
Painful or difficult urination
Women: Hysterectomy (Ovaries?)
Menopause
Currently Breastfeeding
Date of last menstrual period: _____

Skin: Rashes or itching
Jaundice
Cancer

Nervous System:

Epilepsy or seizures
Loss of consciousness
Recurring headaches or migraine
History of falls

Muscles/Bones/Joints/Extremities:

Arthritis
Phlebitis (Inflammation of veins)
Ankle swelling
Joint replacement surgery

Endocrine:

Diabetes
Thyroid disease

Psychiatric:

Nervous breakdown
Depression
Thoughts of or attempts at suicide

Blood:

Excessive bruising or bleeding
Anemia