



Gastroenterology Consultants P.C.

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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	Medications / ETC you are allergic to (e.g. LATEX)

**Have you been on Steroids/ 6MP or Azathioprine ? 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:
<input type="checkbox"/> <b>Colonoscopy</b>		
<input type="checkbox"/> EGD (Endoscopy)		
<input type="checkbox"/> Capsule Endoscopy		
<input type="checkbox"/> ERCP		
<input type="checkbox"/> CT SCAN		
<input type="checkbox"/> Ultrasound		
<input type="checkbox"/> UGI Series		
<input type="checkbox"/> Small Bowel Series		
<input type="checkbox"/> Barium Enema		
<input type="checkbox"/> MRI		
<input type="checkbox"/> <b>Other:</b>		
<input type="checkbox"/> Other:		

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

<input type="checkbox"/> Barrett's Esophagus	<input type="checkbox"/> Gastritis
<input type="checkbox"/> Upper GI Bleeding	<input type="checkbox"/> Gallbladder Disease
<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Hepatitis Type
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Hiatal Hernia
<input type="checkbox"/> <b>Colon Cancer When?</b>	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Constipation	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> <b>Crohn's Disease Location</b> _____	<input type="checkbox"/> Ulcer Disease (Gastric or Peptic)
<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> <b>Ulcerative Colitis</b>
<input type="checkbox"/> Esophageal Reflux	<b>OTHER</b>

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

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes Mellitus
<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Hyperlipidemia
<input type="checkbox"/> <b>Cancer <u>TYPE/Location</u></b>	<input type="checkbox"/> Hypertension
	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> COPD	<input type="checkbox"/> Neurologic Disorders
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Thyroid Disorders
<input type="checkbox"/> Coronary Artery Disease/Heart Attack	<input type="checkbox"/> 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
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Coronary Artery Bypass Graft	
<input type="checkbox"/> Biliary Surgery		<input type="checkbox"/> Heart Valve Replacement	
<input type="checkbox"/> Fistula Surgery		<input type="checkbox"/> Hernia Repair	
<input type="checkbox"/> Colon Polyps		<input type="checkbox"/> Inguinal Hernia Repair	
<input type="checkbox"/> Colon Resection Partial		<input type="checkbox"/> Pacemaker Placement	
<input type="checkbox"/> Hemorrhoidectomy		<input type="checkbox"/> Ovaries removed	
<input type="checkbox"/> Gastric Surgery		<input type="checkbox"/> Tonsils-Adenoids	
<input type="checkbox"/> Small Bowel Resection		<input type="checkbox"/> TURP	
<input type="checkbox"/> Ulcer Surgery		<input type="checkbox"/> Prostate Radiation seeds	
<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Gastric Lap Band	
<input type="checkbox"/> Gall Bladder Removal		<input type="checkbox"/> Other:	

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

Diagnosis	Relationship	Diagnosis	Relationship
Breast Cancer		Diabetes	
<b>Colon Cancer</b>		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 \_\_\_\_\_