Comprehensive Patient Questionnaire

Name: _____ Age: _____

DOB: _____ Height: _____ Weight: _____ □ Male □ Female □ Pregnant

Referring Doctor Information:	**Primary Doctor Information:**
Name:	Name:
Specialty:	Specialty:
City/State:	City/State:
Phone: Fax:	Phone: Fax:

Reason for Visit: _____

Current Symptoms: (**Check all that apply**)

___Abdominal/Chest/Neck/Pain
___Diarrhea
___Constipation
___Change in bowel movements
___Blood in bowel movements
___Nausea
___Vomiting
___Heartburn or indigestion
___Anemia
___Difficulty swallowing
____Jaundice
____Hepatitis
____Abnormal liver tests
____Gallbladder problems
____Abnormal X-ray or scan
____History of colon cancer or polyps
____History of Crohn's or colitis
____History of liver problems
____Family history of colon cancer or polyps
____Family history of liver problems

Have you previously had gastroenterology tests?

___Endoscopy (EGD)	Date: _____	Results: _____
___Colonoscopy	Date: _____	Results: _____
___CT scan	Date: _____	Results: _____
___MRI	Date: _____	Results: _____
___Barium enema	Date: _____	Results: _____
___Upper GI	Date: _____	Results: _____
___Liver biopsy	Date: _____	Results: _____
___X-rays/Ultrasound	Date: _____	Results: _____

Allergies to Medications:	Reactions:	Allergy to:
_____	_____	Dye used in X-ray tests?
_____	_____	**YES** or **NO**
_____	_____	Food type: _____
_____	_____	_____
		_____

Current Medications and doses if possible (Include over –the-counter)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Current/previous medical problems: (Such as diabetes, asthma, heart disease, blood clots, etc.)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Previous surgeries: (Type of operation and approximate date)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Social history:

Substance	Current Use	Previous Use	Type/Amount	How Long/Frequency	If Stopped, when?
Caffeine (coffee,tea,soda)					
Tobacco					
Alcohol					
Recreational or Street drugs					

1.) Education: How many years of school have you completed? _____

2.) Occupation: _____
Current employment status: □ Employed □ Unemployed □ Homemaker □ Retired

3.) Disability: Are you disabled? **NO** or **YES** Cause: _____

4.) Marital Status : □Single □Married □Separated □Divorce □Widowed

5.) Current Spouse: □N/A □Alive □Health problems or cause of Death _____
If alive, current employment status: □Homemaker □Employed □Retired □Unemployed

6.) Number of Children: _____

7.) Have you ever been physically, sexually, or emotionally abused? **YES** or **NO**

Diseases that run in your family:

□ Adopted

	ALIVE/DECEASED	CONDITIONS	CANCERS
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
GRANDPARENTS			
OTHER CLOSE RELATIVE			