

PATIENT QUESTIONNAIRE

Date: _____ **Name:** _____ **DOB:** _____

Reason for Visit: Colonoscopy Upper Endoscopy Office Visit for: _____

Height _____ Weight _____

Do any of the following apply to you? None

- Pacemaker Defibrillator
 Kidney Dialysis Blood Thinners (Such as Coumadin, Plavix, Aggrenox, Lovenox)

SYSTEM REVIEW: Do you experience any of the following: None

- | | | | | | |
|--|---|--|--|---|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Rash | <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Rhinitis | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Lumps | <input type="checkbox"/> Cough | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Sores | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> <u>Fainting</u> | <input type="checkbox"/> Hives | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> <u>Nail Changes</u> | <input type="checkbox"/> <u>Wheezing</u> | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> <u>+ TB Test</u> | <input type="checkbox"/> Change in Bowel Habits |
| <input type="checkbox"/> <u>Fatigue</u> | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Excess Thirst | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Blood in Stool |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Excess Sweating | <input type="checkbox"/> <u>Swollen Glands</u> | <input type="checkbox"/> Nausea | <input type="checkbox"/> Painful Bowels |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Bloody Nose | <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Yellow eye/skin |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> <u>Heat Intolerance</u> | <input type="checkbox"/> Burning w/ Urination | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> <u>Joint Swelling</u> | <input type="checkbox"/> <u>Bleeding Gums</u> | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> <u>UTI's</u> | <input type="checkbox"/> Constipation | |

Provide details/list other symptoms: _____

PAST MEDICAL HISTORY: Have you had any of the following diseases: None

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> GI Bleeding | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizure | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Hepatitis A, B, or C | | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Atrial Fibrillation | | <input type="checkbox"/> Gout | | |
| <input type="checkbox"/> Cancer (specify : _____) | | | | |

PAST SURGICAL HISTORY: If you have had any of the follow surgeries, list date and type if any. None

- | | | | |
|--------------------------------------|-------------|---|-------------|
| <input type="checkbox"/> Gallbladder | Date: _____ | <input type="checkbox"/> Appendix | Date: _____ |
| <input type="checkbox"/> Stomach | Date: _____ | <input type="checkbox"/> Hysterectomy | Date: _____ |
| <input type="checkbox"/> Appendix | Date: _____ | <input type="checkbox"/> Heart Bypass | Date: _____ |
| <input type="checkbox"/> Hernia | Date: _____ | <input type="checkbox"/> Transplantation | Date: _____ |
| <input type="checkbox"/> Colon | Date: _____ | <input type="checkbox"/> Heart/Artery/Stent | Date: _____ |
| <input type="checkbox"/> Other: | Date: _____ | | |

PAST ENDOSCOPIC HISTORY: What prior endoscopies have you had? None

- | | | |
|--|-------------|----------------|
| <input type="checkbox"/> Upper Endoscopy | Date: _____ | Results: _____ |
| <input type="checkbox"/> Colonoscopy | Date: _____ | Results: _____ |

I am a returning patient; please see my chart for previous procedures

