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ADULT GASTROENTEROLOGY NEW PATIENT QUESTIONNAIRE

Please COMPLETE and bring with your or return by email prior to your visit. Please answer all questions to the best of your ability.

YOUR INFORMATION:

Today's Date:_____

Name:_____ Date of Birth:_____ Age:_____years_____months

YOUR SYMPTOMS/YOUR CONCERNS: (check all that apply)

◯Abdominal pain◯Abnormal liver tests◯ Bloating/Gas◯ Blood in stool ◯ Celiac Disease ◯Constipation ◯Crohn's disease
◯Diarrhea ◯ Hepatitis◯ Jaundice ◯ Obesity ◯ Rectal pain ◯Reflux ◯Slow weight gain ◯ Soiling/stooling accidents
◯Swallowing pain/dysfunction ◯ Ulcerative colitis ◯ Vomiting ◯ Weight loss Other:_____

REVIEW OF YOUR CURRENT SYMPTOMS:

(Check all **CURRENT** medical problems)

GENERAL/CONSTITUTIONAL
- ◯ Recurring fevers
- ◯ Chronic fatigue
- ◯ Failure to thrive
- ◯ Slow growth
- ◯ Developmental delay

EYE/VISION:
- ◯ Wears glasses
- ◯ Eye surgery
- ◯ Lazy eye
- ◯ Eye injury
- ◯ Other:_____

EARS/NOSE/THROAT:
- ◯ Hearing loss
- ◯ Recurring ear infections
- ◯ Recurring sinus infections
- ◯ Recurring strep throat
- ◯ Ringing in ears

RESPIRATORY:
- ◯ Pneumonia
- ◯ Asthma
- ◯ Reactive airways
- ◯ Croup
- ◯ Persistent cough
- ◯ Shortness of breath
- ◯ Other:_____

CARDIOVASCULAR:
- Murmur
- Heart problems
- explain:_____

KIDNEY/URINARY:
- ◯ Urinary tract infections
- ◯ Bed wetting
- ◯ Kidney diseases
- ◯ Kidney reflux
- ◯ Ovary or testicle diseases

MUSCLES/JOINTS:
- ◯ Pain/ache in joints
- ◯ Arthritis
- ◯ Stiffness/limited on movement
- ◯ Pain/ache in muscles

NEUROLOGIC:
- ◯ Headaches
- ◯ Cerebral palsy
- ◯ Hydrocephalus
- ◯ Migraine
- ◯ Seizures
- ◯ Faintness/Dizziness
- ◯ Insomnia

PSYCHOSOCIAL:
- ◯ Depression
- ◯ Anxiety
- ◯ Bipolar
- ◯ Anorexia
- ◯ Mood swings
- ◯ Aggression
- ◯ Bulimia
- ◯ ADHD
- ◯ Behavior disorder
- ◯ Other:_____
- _____

ENDOCRINE:
- ◯ Diabetes
- ◯ Thyroid disease
- ◯ Growth problems
- ◯ Kidney reflux
- ◯ Ovary or testicle diseases

WEIGHT:
- ◯ Binge eating/drinking
- ◯ Craving certain foods
- ◯ Excessive weight
- ◯ Compulsive eating
- ◯ Water retention
- ◯ Underweight

ALLERGY/IMMUNE:
- ◯ Hay fever
- ◯ Immune deficiency
- ◯ HIV/AIDS
- ◯ Other:_____

BLOOD/CIRCULATION:
- ◯Anemia
- ◯Bleeding tendencies
- ◯Sickle cell trait
- ◯Sickle cell disease
- ◯Thalassemia
- ◯Other:_____
- _____

SKIN:
- ◯Acne
- ◯Hives
- ◯Rashes/dry skin
- ◯Hair loss
- ◯Flushing/hot flashes
- ◯Excessive sweating

GASTROINTESTINAL:

◯*Abdominal Pain*
- ◯Epigastric ◯Periumbilical ◯ Diffuse
- ◯ Right Lower Quadrant
- ◯ Left Lower Quadrant
- ◯ Awaken During Night
- ◯ Awaken in A.M.

Duration of Pain:
- ◯ Constant◯Comes/Goes◯<5min ◯1-2hrs.

Character:
- ◯ Sharp ◯Dull ◯Burning ◯Bloating

Radiation:
- ◯ Back ◯Chest

◯*Regurgitation:*
- ◯ Yes ◯ No
- ◯Heartburn
- ◯Belching
- ◯GERD

◯ *Vomiting:*
- ◯ Yes ◯ No ◯ Bright Blood ◯ Dark Blood

Frequency:
- ◯ Daily ◯Weekly ◯Monthly
- ◯ Progressively Worse ◯No Recent Change

Nausea:
- ◯ Yes ◯ No

◯ *Stools:*
- ◯ Formed◯ Loose◯ Diarrhea◯Constipated

Frequency:
- ◯ Daily◯Every Other Day◯2x/wk ◯<1x/wk

Soiling:
- ◯Yes ◯ No

Rectal Bleeding:
- ◯Yes ◯ No

Frequency:
- ◯Daily ◯1x/wk ◯1x/mo.

Pain:
- ◯ Yes ◯No

Abd Pain Improves With BM:
- ◯Yes ◯ No

Flatulence:
- ◯ Yes ◯ No

FEMALE HEALTH: LMP:_____

◯ Normal ◯ Irregular ◯Menopausal Problems:_____

_____

_____

Please continue to next page

PAST MEDICAL HISTORY

Dietary Intolerance:_____

_____

_____

Do you have any allergies to medications or foods?

Medications(list with reaction) :_____

_____

Foods:(list)_____

_____

_____

YOUR MEDICAL HISTORY AND PAST SURGERIES:

(Check all **PAST** medical problems)

GENERAL/CONSTITUTIONAL:
- ⬭ Recurring fevers
- ⬭ Chronic fatigue
- ⬭ Failure to thrive
- ⬭ Slow growth
- ⬭ Developmental delay

EYE/VISION:
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- ⬭ Pneumonia
- ⬭ Asthma
- ⬭ Reactive airways
- ⬭ Croup
- ⬭ Persistent cough
- ⬭ Shortness of breath
- ⬭ Other:_____

CARDIOVASCULAR:
- ⬭ Murmur
- ⬭ Heart problems

explain:_____

GASTROINTESTINAL:
- ⬭ Constipation
- ⬭ Bloated feeling
- ⬭ Diarrhea
- ⬭ Vomiting
- ⬭ GERD
- ⬭ Stomach pain
- ⬭ Reflux/Heartburn
- ⬭ Belching or passing gas
- ⬭ Feeding problems
- ⬭ Soiling
- ⬭ Other:_____

KIDNEY/URINARY:
- ⬭ Urinary tract infections
- ⬭ Bed wetting
- ⬭ Kidney diseases
- ⬭ Kidney reflux
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- ⬭ Hives
- ⬭ Rashes/dry skin
- ⬭ Hair loss
- ⬭ Flushing/hot flashes
- ⬭ Excessive sweating

OTHER: Any additional information about you

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Major surgeries (date & type of):_____ _____

_____ _____

_____ _____

_____ _____

Please continue to next page

YOUR MEDICATIONS:

Please list all current medications your taking, including over-the-counter medications, vitamins, minerals, or supplements. If medications were recently started, please state when.

Medication Name	Dose	Frequency	When Started

YOUR PHARMACY:

Pharmacy name:_____Pharmacy phone number:_____

YOUR MEDICAL TESTS:

What tests have completed prior to this visit?

- ⬭ Lab (Bloodwork) Where and when was this test performed?_____
- ⬭ X-Rays Where and when was this test performed?_____
- ⬭ CT Scan Where and when was this test performed?_____
- ⬭ Ultrasound Where and when was this test performed?_____
- ⬭ Other Where and when was this test performed?_____

OTHER MEDICAL TREATMENTS:

Last date antibiotics received:_____

Are your general health/screenings up-to-date?

⬭Physical exams ⬭Immunizations ⬭ Dental care ⬭ Pap test ⬭ Bone density ⬭Colonoscopy ⬭ Eye exam ⬭ Hearing test

SOCIAL HISTORY:

⬭Married ⬭ Separated ⬭Divorced ⬭Not Married

Who lives at home? _____

Does patient or family member smoke? ⬭NO ⬭YES

Type:_____ Quantity:_____ Frequency:_____

Does patient or family member use alcohol or recreational drugs? ⬭NO ⬭Yes

Type:_____ Quantity:_____ Frequency:_____

Patient eats (#)_____meals and (#) _____snacks / day

Patient exercises _____hours / week doing_____

Patient wears ⬭ seat belt ⬭ bicycle helmet

Patient sometimes feels ⬭anxious ⬭ depressed ⬭bored ⬭suicidal

Please continue to next page

HOME ENVIRONMENT AND DIET:

Do you drink: ⬭ City water w/fluoride ⬭ City water w/o fluoride ⬭ Well water ⬭ Bottled water ⬭ Milk ⬭ Juices ⬭ Soda ⬭ Tea/Coffee ⬭ Other:_____

Is there a smoker in the house? ⬭ Yes ⬭ No Do they smoke: ⬭ Inside ⬭ Outside

Any pets in the house? ⬭ Yes ⬭ No If yes, ⬭ Dog ⬭ Cat ⬭ Other:_____

Have you traveled out of the U.S.A.? ⬭ Yes ⬭ No If yes, when and where:_____

Do you have dietary restrictions? ⬭ Lactose Free ⬭ Gluten Free ⬭ Low Fructose ⬭ Low Glycemic ⬭ High Fiber ⬭ Cow's Milk Protein Free ⬭ Other:_____

YOUR FAMILY MEDICAL HISTORY:

Other than you, has anyone in the family had any of the following conditions?
(Please indicate nest to each applicable condition using the following codes): **M**=Mother/**F**=Father/**B**=Brother/**S**=Sister/**MGM**=Maternal Grandmother **MGF**=Maternal Grandfather/**PGM**=Paternal Grandmother/**PGF**=Paternal Grandfather/**MA**=Maternal Aunt/**MU**=Maternal Uncle/**PA**=Paternal Aunt **PU**=Paternal Uncle/**O**=Other(please indicate who)_____

◯ Celiac disease	◯ Colon cancer	◯ Constipation	◯ Crohn's disease
◯ Cystic fibrosis	◯ Gastroesophageal (acid) reflux	◯ Gastrointestinal disease	◯ Irritable bowel disease
◯ Liver disease	◯ Gallbladder disease	◯ Polyps	◯ Ulcerative colitis
◯ Blood disorders	◯ Allergic diseases (specify)_____	◯ Anesthesia problems	◯ Bleeding problems
◯ High blood pressure (hypertension)	◯ Diabetes (type)	◯ Headaches	◯ Heart disease
◯ Lung Problems	◯ Infant child death	◯ Kidney disease	◯ High cholesterol
◯ Ulcers	◯ SIDS	◯ Thyroid disease	◯ Other:_____

ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOU?:

_____
_____
_____
_____
_____