Amarillo Diagnostic Clinic, P.A.

GASTROENTEROLOGY

PATIENT QUESTIONNAIRE - PLEASE PRINT

Full name:_____Age:

Date:_____Address:

Telephone Number:_____Email address:

CHIEF COMPLAINTS(List the problems about which you came to see the doctor)

1) _____

2)_____

3)_____

Referring Physician_____ Other Physician

What pharmacy would you like us to call to fill your prescriptions:_____

PAST MEDICAL HISTORY

Please check any of the following medical illnesses that you NOW have, or list any others that are not listed below.

☐ Change in appetite	☐ Pus or mucus in stool	☐ Itching
☐ Weight gain or loss	☐ Rectal bleeding	☐ Pain in relationship to eating
☐ Painful swallowing	☐ Tarry black stool	☐ Stomach pain relieved by food or milk
☐ Heartburn	☐ Rectal pain or itching	
☐ Nausea	☐ Painful bowel movements	☐ Feel full quickly
☐ Vomiting	☐ Abdominal swelling	☐ Problems controlling bowel movements
☐ Abdominal pain	☐ Jaundice or yellow eyes	
☐ Constipation	☐ _____	☐ _____
☐ Diarrhea		

Please check any of the following medical illnesses that you have EVER had.

☐ Ulcer	☐ Gallbladder disease	☐ Crohn's
☐ Hepatitis	☐ Colon polyps	☐ Pancreatitis
☐ Jaundice	☐ Colon cancer	☐ Hiatal hernia
☐ Liver problems	☐ Diverticulitis	☐ Vomiting blood
☐ Hep A, B, or C	☐ Colitis	☐ Blood in stool

OPERATIONS OR SURGERIES

Please list all past operations, including cataract surgery, what type of surgery it was and when it was done

TYPE		DATE
PREVIOUS COLONOSCOPY	☐ YES ☐ NO	
PREVIOUS EGD	☐ YES ☐ NO	

Major Medical Illnesses

Date	Place	Doctor

HAVE YOU HAD A BLOOD TRANSFUSION	DATE
□ Yes □ No	

FAMILY HISTORY

Please list any diseases which tend to "run in your family" especially high blood pressure, diabetes, heart disease, cancer, gout, asthma, stomach ulcers, arthritis, allergies, epilepsy, tuberculosis, cystic fibrosis, muscle disease, stroke or thyroid disease.

Marital Status

□ Single □ Married □ Separated □ Divorced □ Widowed □ Other

Father's History

Is your Father? □ Alive – Age _____ □ Deceased – Age _____

What types of health problems if any did he have?

Mother's History

Is your Mother? □ Alive – Age _____ □ Deceased – Age _____

What types of health problems if any did she have?

Do you have any brothers?

How many? □ Alive – Ages _____ □ Deceased – Ages _____

What types of health problems do/did they have?

Do you have any sisters?

How many? □ Alive – Ages _____ □ Deceased – Ages _____

What types of health problems do/did they have?

If you served in the military:

Were you ill while in the military? □ Yes □ No What was the nature of the illness?

Did you serve overseas? □ Yes □ No If yes, where & when?

Occupation

Current employment status: □ Disabled □ Part time □ Full time □ Retired □ Self-employed □ Other

Occupation:_____

HABITS

Have you ever smoked cigarettes regularly? □ Yes □ No If yes, how many packs per day? (avg)

How many years? Are you still smoking? □ Yes □ No If no, when did you stop?

Do you use snuff or chewing tobacco? □ Yes □ No Do you drink alcohol? □ Yes □ No

How many beers daily? How many years?

How many mixed drinks or glasses of wine daily? How many years?

Do you have any drug, nicotine or alcohol habits which concern you? □ Yes □ No

Do you regularly use sleeping pills, tranquilizers, or pain killers? □ Yes □ No

If yes, which ones?

Do you currently use marijuana, cocaine or other "recreational" drugs? □ Yes □ No

ANIMAL CONTACT

Please list all pets or any other animals which you may have been in contact with in the past year:

_____

TRAVEL

If you have traveled out of the Amarillo area in the past year, please list the places where you have been:

_____

IMMUNIZATIONS

Hepatitis A_____ Flu_____ Tetanus

Hepatitis B_____ Pneumovax_____ Other

TB skin test: Result_____ When_____ Doctor_____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING

Name	Dose	How often	Dr. prescribing	How long

Non-Prescription (over the counter) medications including vitamins, health food or herbal products

Name	Dose	How often	Dr. prescribing	How long

Allergies to Medications and Reactions

Please list any medications or products you have taken which cause a <u>true</u> allergic reaction (hives, itching, rash, or difficulty breathing)

Medication	Reaction

Food Allergies/Intolerances and Reactions	
Food	**Reaction**

REVIEW OF SYSTEMS

Please check any of the following symptoms or problems you are currently experiencing. If the problem has been resolved, leave it blank. If you are unsure, place a question mark (?) by the medical issue.

General □ Weight loss □ Weight gain □ Fatigue □ Fever □ Night sweats Do you eat a special diet? □Yes □No Do you exercise regularly? □Yes □No	**Skin** □ Recent change in hair distribution □ Changes in skin color □ Itching □ Rash □ Hair loss □ Other_____	**Head/Ear/Eyes/Nose/Throat** □ Diplopia (double vision) □ Glaucoma □ Hearing loss □ Nose bleeds □ Sore throat □ Other_____
Neck □ Neck mass □ Neck pain □ Neck stiffness □ Swollen glands □ Other_____	**Respiratory** □ Cough □ History of Tuberculosis □ Shortness of breath □ Wheezing □ Other_____	**Breast/GYN** □ Breast discharge □ Breast swelling □ Breast mass □ Breast tenderness □ Menses:Last one?_____ □ # Miscarriage _____ □ Other_____
Cardiovascular □ Chest pain □ Edema (swelling)_____ □ Fast/Irregular heartbeat □ Orthopnea (trouble breathing while lying down) □ Other_____	**Gastrointestinal** □ Abdominal pain □ Nausea □ Vomiting □ Constipation/Diarrhea □ Reflux □ Other_____	**Genitourinary** □ Blood in urine □ Dysuria (pain with urination) □ Frequency of urination □ Discharge □ Nocturia (excessive urination at night) □ History of malignancy (cancer) □ Other_____
Musculoskeletal □ Arthritis □ Back pain □ Joint pain □ Other_____	**Neurological** □ Headaches □ Seizures □ Strokes □ Other_____	**Psychological** □ Anxiety □ Depression □ Insomnia □ Other_____
Endocrine □ Cold intolerance □ Heat intolerance □ Thyroid problems □ Other_____	**Hematological** □ Anemia □ Easy bleeding □ Easy bruising □ Other_____	**Other**

Signature:_____ Date:_____

Reviewed by Physician: _____