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

Signature:_____ Date:_____

Reviewed by Physician:_____