GRAVES GILBERT CLINIC
DEPARTMENT OF GASTROENTEROLOGY

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Thank you for making an appointment with Gastroenterology.

Please arrive on date: _____ at: _____

Your appointment time is: _____ but we require you to arrive 30 minutes early.

<u>Any labs, radiology testing, or procedures/scopes that may be needed will be discussed at your office visit.</u>

Enclosed is a patient questionnaire that we request you complete prior to coming to the office for your appointment. The information you supply by filling out the questionnaire will facilitate your office visit. By completing this form at home, we hope you will have more time to consider the questions and therefore supply a more comprehensive medical history.

We appreciate your assistance with answers to the questionnaire and look forward to seeing you in the office on the above date.

PATIENT QUESTIONNAIRE FOR GASTROENTEROLOGY

Name: _____ DOB: _____ Date: _____

Referring Physician: _____ Family Physician: _____

1. What is the reason you are seeing the doctor?

2. How long have you had this problem?

3. Have you had any prior evaluation or testing (such as x-rays or blood tests) related to this problem? If so, what has been done and where were the examinations performed.

4. Have you been treated with any medications for your present problem? If so, what were the medications and who was the doctor that prescribed them.

5. Have you ever had an EGD/Colonoscopy (upper/lower scope)? If yes, when and where?

Past Medical History

1. Please list any major adult illnesses (such as pneumonia or hepatitis) you have had and the years in which they occurred.

2. Please list all surgical procedures or operations that you have had and the years that they were performed.

3. Please list all the medications and over the counter medications including supplements that you are presently taking, the dose of each, the frequency that you take them.

4. If you are allergic to any medications, please list all of those medications here and the allergic reaction that each medication causes.

5. Have you ever received a transfusion? If so, when and under what circumstances.

Personal and Social History

1 . Do you use tobacco products? If you smoke, how many packs of cigarettes per day do you smoke and how many years have you smoked? If you did smoke cigarettes and have stopped, in what year did you stop and how many years did you smoke?

2. Do you drink alcohol? If you do, how would you characterize the amount you drink per day, week, month or year? Have you ever had a legal problem because of alcohol?

3. Are you presently working or retired? If you are working, what is your job description and who is your employer? Do you feel your present problem is related to your job? If you are retired, what jobs have you held prior to your retirement?

4. What is your marital status? If you have children, what are their ages and general medical health?

5. What was the highest grade you completed in school?

Family History

Please note any of the following conditions that may be inherited in your family and if present please list the family members (mother, father, sons, daughters, or grandparents) who had the condition.

- ❑ Diabetes
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Stroke
- ❑ Kidney problems
- ❑ History of alcohol problems
- ❑ Colon polyps
- ❑ Colon cancer
- ❑ Other diseases of the digestive tract, liver or pancreas
- ❑ Other types of cancer
- ❑ Depression

Review of Systems

Please indicate any of the following symptoms that **apply to you**.

HEENT

- ❑ Frequent headaches
- ❑ Changes in vision
- ❑ Recurrent sinus infection
- ❑ History of goiter or thyroid disease
- ❑ History of head trauma
- ❑ Difficulty hearing
- ❑ Hoarseness

RESPIRATORY

- ❑ Chronic cough
- ❑ Shortness of breath at rest
- ❑ Emphysema
- ❑ Other chronic lung disease
- ❑ History of asthma
- ❑ Shortness of breath on exertion
- ❑ Chronic bronchitis
- ❑ Waking at night sweating

CARDIOVASCULAR

❑ History of Rheumatic fever as a child
❑ Valvular heart disease
❑ Chest pain on exertion
❑ Swelling of the ankles or feet
❑ Shortness of breath when lying flat in bed
❑ Require antibiotics before surgical procedures
❑ Elevated cholesterol
❑ Heart murmur
❑ History of heart attack
❑ History of congestive heart failure
❑ Waking at night short of breath
❑ Irregular heart rate or rhythm
❑ High blood pressure

GENITOURINARY

❑ Difficulty urinating
❑ Getting up at night to urinate
❑ Urinary incontinence
❑ Bleeding on urination
❑ Other kidney disease
❑ Burning on urination
❑ Increased frequency of urination
❑ History of frequent urinary tract infections
❑ History of kidney stones

Women only:

❑ History of menstrual irregularity
The date of my last
menstrual cycle was _____
❑ My symptoms seem related to my
menstrual cycle
❑ Postmenopausal
Age at my last
menstrual cycle was _____

Men only:

❑ History of prostate problems
❑ Difficulty starting urine stream

NEUROMUSCULAR

❑ Nervousness
❑ Change in memory
❑ Episodes of loss of consciousness
❑ Loss of sensation
❑ Tremors or muscle twitching
❑ Difficulty sleeping
❑ Dizziness
❑ Seizures or convulsions
❑ Paralysis
❑ Muscle weakness or pain

BONE AND JOINT

❑ History of arthritis
Type of arthritis: ❑ Osteoarthritis
❑ Rheumatoid
❑ Gout
❑ Redness, swelling or warmth of joints
❑ History of broken bones, including hips
❑ Other conditions effecting bones/joints
such as Lupus, fibromyalgia

ENDOCRINE

❑ History of diabetes
Year diagnosis was made _____
❑ Controlled with oral medication
❑ Controlled with insulin
❑ Diet restricted to _____ calories per day
❑ History of thyroid disease
❑ Other endocrine (glandular) condition