Digestive Health New Patient Questionnaire

Name: _____ Date of Birth: _____

Reason for Visit: _____ Today's Date: _____

Medications:

Please list the medications you are taking (prescription, over the counter, and supplements). Complete the column for dosage and mark the box for how often you are taking each medication. Attach additional pages if needed.

Medication Name	Dosage	How often you are taking?			
		1x/day	2x/day	3x/day	As needed

Allergies:

If you have any new allergies, please list them below:

	None		Latex
	Antibiotics (*please specify below)*		Egg
	X-ray/Radiology Contrast		Other (*please specify below)*

_____

_____

Preferred Pharmacy: _____

Family History:

Have your blood relatives had any of the following? *If yes, please mark the box for their relation to you.*

	Mother	Father	Sibling	Grandparent
Colon Cancer				
Colon Polyps				
Esophageal Cancer				
Crohn's Disease				
Liver Disease				
Pancreatic Cancer				
Stomach Cancer				
Ulcerative Colitis				
Gallbladder Problems				
Breast Cancer				
Ovarian Cancer				
Uterine Cancer				

Past Endoscopic History:

Have you had any of the following endoscopies? *If the answer is yes, please mark the box and complete the additional spaces.*

Type of Endoscopy	When	Did they find Ploys
☐ Colonoscopy/Lower scope		☐ Yes ☐ No
☐ EGD/Upper scope		☐ Yes ☐ No

Have you had a problem with sedation or anesthesia? (describe)

_____

_____

History of Vaccinations:

Please mark the box if you have any of the following vaccinations and provide the date.

☐ Hepatitis A Date:	☐ Pneumovax (Pneumonia) Date:
☐ Hepatitis B Date:	☐ Flu Shot (for this season) Date:

Past Medical History:

Have you EVER experienced any of the following? *If yes, please mark the box.*

☐ Anemia	☐ Heart Attack	☐ Kidney Disease
☐ Anxiety Disorder	☐ Heart Failure	☐ Liver Disease
☐ Artificial Joints	☐ Heart Murmur	☐ Pacemaker
☐ Asthma	☐ Heart Valve Replacement	☐ Pancreatitis
☐ Bleeding Disorder	☐ Hepatitis	☐ Rheumatic Fever
☐ Colon Polyps	☐ Hiatal Hernia	☐ Seizure Disorder
☐ Colon/Rectal Cancer	☐ High Blood Pressure	☐ Sleep Disorder
☐ COPD/Emphysema	☐ High Cholesterol	☐ Stomach Cancer
☐ Crohn's Disease	☐ History of Tuberculosis	☐ Stroke
☐ Depression	☐ History of Blood Clots	☐ Tattoos
☐ Diabetes	☐ HIV Infection	☐ Thyroid Disorders
☐ Diverticulosis	☐ Implantable Defibrillator	☐ Ulcerative Colitis
☐ Diverticulitis	☐ Implantable Stimulator	☐ Using Home Oxygen
☐ Frequent Bladder Infection	☐ Irritable Bowel Syndrome	

Past Surgical History:

Have you had any of the following surgeries? *If the answer is yes, please mark the box.*

☐ Appendix Removal	☐ Heart Surgery	☐ Portion of Bowel
☐ Gallbladder Removal	☐ Hysterectomy	☐ Stomach Surgery

Please list any additional surgeries:

_____

_____

Signature: _____ Date: _____