Gastroenterology Specialists of Dekalb

Patient Health Questionnaire

Date:_____

Name: _____

Date of Birth: _____**Age:**_____

Referring Physician/PCP: _____

Mode: ambulatory wheel chair stretcher

Do you need an interpreter? Yes ____ No____ If Yes, arranged?_____Refused: _____

Reason for visit today _____

Past Medical History *Check if you have a history of any problems listed below*

- ❑Heart failure
- ❑Heart attack
- ❑Irregular heart beat
- ❑Heart murmur
- ❑Antibiotics before dental work
- ❑High blood pressure
- ❑Diabetes
- ❑High Cholesterol
- ❑COPD/Emphysema/Asthma
- ❑Hypo/Hyperthyroid
- ❑Clotting disorder
- ❑Blood Transfusion
- ❑ DVT/PE
- ❑Anemia
- ❑Ulcers
- ❑Colon cancer
- ❑Colon polyps
- ❑Hepatitis
- ❑Ulcerative Colitis
- ❑Crohn's Disease
- ❑Irritable/spastic bowel
- ❑GERD/Reflux
- ❑Breast cancer
- ❑Prostate cancer
- ❑Uterine cancer
- ❑Kidney disease/Dialysis
- ❑Tuberculosis/PPD
- ❑HIV/AIDS
- ❑Arthritis/Rheumatoid
- ❑Stroke
- ❑Seizure Disorder
- ❑Depression
- ❑Anxiety
- ❑Endometriosis
- ❑Sleep apnea
- ❑Other cancer_____
- ❑Other_____

Past Surgical History *Check if you have had any of the surgeries below and list year of your surgery*

- ❑Gallbladder removal_____
- ❑Appendectomy_____
- ❑Colon or bowel resection_____
- ❑Ulcer surgery_____
- ❑Artificial Joint_____
- ❑Heart bypass_____
- ❑Artificial heart valve_____
- ❑Coronary Stent_____
- ❑Upper Endoscopy _____
- ❑Mastectomy/Lumpectomy_____
- ❑Hysterectomy_____
- ❑Ovary removal_____
- ❑C-Section_____
- ❑Tubal ligation_____
- ❑Hernia Repair_____
- ❑Hemorrhoid removal_____
- ❑Colonoscopy _____
- ❑Other

_____

Current Medications *Include **prescription, over the counter, home and herbal remedies***

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication and Food Allergies *Include type of reaction* ❑ No known allergies

_____ _____

Family Medical History *Check if a blood relative has had a history of any problem listed below*

- ❑Heart Disease
- ❑High Blood Pressure
- ❑Diabetes
- ❑Breast Cancer
- ❑Uterine Cancer
- ❑Other_____
- ❑Colon Cancer
- ❑Colon Polyps
- ❑Ulcers
- ❑Ulcerative Colitis
- ❑Crohn's Disease
- ❑ Stomach Cancer
- ❑Liver Disease
- ❑Pancreatic problem
- ❑Gallbladder problem
- ❑Anemia
- ❑Other_____
- ❑Other_____

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Social History

Smoking: ❑None now ❑None ever
Currently how many/day? _____ # of years? _____
In past how many/day? _____# of years? _____
When did you quit? _____

Alcohol: ❑None now ❑ None ever
How many cocktails/beer/wine_____ daily/weekly/monthly/yearly (Circle one)

Cups of coffee/day_____ Caffienated soft drinks/day_____

History of recreational drug use? ❑None IV drugs_____ Intranasal_____ Other_____

Occupation _____ ❑ Disabled ❑ Retired ❑ Unemployed

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Domestic partnership

Children ages and health_____ _____

Review of Systems

Check symptoms you are currently having or have had in the last 3 months

❑Fatigue
❑Weight loss-unintended
❑Weight gain
❑Fever

❑Rash
❑Itching
❑Jaundice/Yellowing of eyes

❑Swelling in neck
❑Sores in mouth
❑Ringing in ears
❑Vertigo
❑Difficulty hearing
❑Nose bleeds
❑Pain in throat
❑Hoarseness
❑Glaucoma/Cataracts

❑Cough
❑Shortness of breath
- ❑-with exertion
- ❑-when laying down
- ❑-at night when sleeping

❑Wheezing

❑Chest pain
❑Swelling in legs
❑Pain in calf when walking

❑Nausea
❑Vomiting
❑Loss of appetite
❑Heartburn
❑Pain when swallowing
❑Food sticking in chest
❑Abdominal pain
- ❑-after eating
- ❑-before eating
- ❑-at night

❑Abdominal bloating/swelling
❑Diarrhea
- ❑-at night

❑Constipation
❑Blood in stool
❑Oily stools
❑Rectal pain/pressure
❑Leakage of stool

❑ Loss of bladder control
- ❑-when coughing/laughing

❑Burning with urination
❑Frequent urination
❑Blood in urine
❑Urinating at night

❑Easy bruising

Men:
- ❑-Slow urine stream
- ❑-Difficulty with erection

Women:
- ❑-Last period_____
- ❑-Irregular periods
- ❑-Heavy menstrual bleeding
- ❑-Painful intercourse

❑Joint pain/swelling

❑Nervousness
❑Depression
❑Insomnia

❑Blackouts
❑Headaches
❑Difficulty speaking
❑Tremors

❑Loss of body hair
❑Increased thirst
❑Heat or cold intolerant

❑Other _____
❑Other_____

❑ All others negative

Patient signature_____ MD/PA signature_____

Date_____ Date_____