Southwest Community Gastroenterology

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Specializing in Gastroenterology & Hepatology

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Patient Information

Patient Name: _____ ☐ female ☐ male

Age: _____ Date of Birth: _____ SSN#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Race: _____ Language: _____

Parent or Spouses Name: _____

Employer: _____ Employer Phone: _____

Primary Care Physician or Family Doctor: _____

Name and address/phone of nearest relative (for emergency use): _____

_____

_____

Insurance Information

PRIMARY INSURANCE INFO
(be sure to bring card to appointment)

Insurance Company: _____

Insured Name: _____

Insured DOB: _____

SECONDARY INSURANCE INFO
(be sure to bring card to appointment)

Insurance Company: _____

Insured Name: _____

Insured DOB: _____

PATIENT MEDICAL QUESTIONNAIRE

Name: _____

Referring Physician: _____

What problem brings you to a gastroenterologist? _____

_____

How long have you had this problem? _____

IF YOU HAVE ALREADY BEEN TESTED OR TREATED FOR THIS PROBLEM, PLEASE COMPLETE THE FOLLOWING:

Test or Treatment	Date	Location	Physician

PLEASE LIST ANY PAST SURGICAL OPERATIONS:

DATE	SURGERY	HOSPITAL

Have you ever had a blood transfusion? ☐ **Yes** ☐ **No**

CURRENT MEDICATIONS, OVER THE COUNTER MEDS AND HERBALS

NAME OF DRUG	DOSE	DATE STARTED

Are you allergic to any medications? ☐ **Yes** ☐ **No**

If yes, please list medication(s) and allergic reaction(s):

PERSONAL HABITS:

Tobacco ☐ Yes ☐ No **Cigarettes per day:** _____ **Years:** _____

Alcohol ☐ Yes ☐ No **Drinks per day:** _____ **Years:** _____

Do you or have you ever used street drugs of any kind? _____ **Type:** _____

Do you have well water or city water? _____

Have you recently traveled outside the United States? _____

Do you require antibiotics before dental procedures? _____

Have you had an upper endoscopy before? _____ **When?** _____

Have you had a colonoscopy before? _____ **When?** _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Colon polyps	☐ Yes	☐ No	**Liver problems**	☐ Yes	☐ No
Colon Cancer	☐ Yes	☐ No	**Thyroid disease**	☐ Yes	☐ No
Other Cancer	☐ Yes	☐ No	**Kidney stones**	☐ Yes	☐ No
Crohn's disease	☐ Yes	☐ No	**Pancreatitis**	☐ Yes	☐ No
Ulcerative colitis	☐ Yes	☐ No	**Diabetes**	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No	**Arthritis**	☐ Yes	☐ No
Hepatitis/Jaundice	☐ Yes	☐ No	**Rheumatic fever**	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	**Gastrointestinal bleeding**	☐ Yes	☐ No
Lung disease	☐ Yes	☐ No	**Depression/ Anxiety**	☐ Yes	☐ No
High cholesterol/lipids	☐ Yes	☐ No	**Hypertension**	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No			

HAS ANYONE IN YOUR FAMILY HAD:

Crohn's disease	☐ Yes	☐ No	**Ulcerative colitis**	☐ Yes	☐ No
Celiac disease	☐ Yes	☐ No	**Colon cancer**	☐ Yes	☐ No
Colon polyps	☐ Yes	☐ No			
Other GI cancers	☐ Yes	☐ No	**(If yes, please list:** _____**)**		

DO YOU HAVE ANY OF THE FOLLOWING?:

Difficulty swallowing	☐	☐	**Bloody/black bowel movements**	☐ Yes	☐ No
Heartburn	☐	☐	**Loss of bowel movement control**	☐ Yes	☐ No
Hoarseness	☐	☐	**Constipation**	☐ Yes	☐ No
Chronic cough	☐	☐	**Diarrhea**	☐ Yes	☐ No
Regurgitation	☐	☐	**Recurrent fevers**	☐ Yes	☐ No
Chest pain	☐	☐	**Fluid in abdomen (ascites)**	☐ Yes	☐ No
Fill up quickly @ meals	☐	☐	**Vomiting blood**	☐ Yes	☐ No
Loss of appetite	☐	☐	**Could you be pregnant**	☐ Yes	☐ No
Nausea	☐	☐	**Vomiting blood**	☐ Yes	☐ No
Change in bowel habits	☐	☐	**Rash**	☐ Yes	☐ No
Joint redness/swelling	☐	☐	**Abdominal pain**	☐ Yes	☐ No
Recent change in weight	☐	☐	**(Pounds gained:** **Pounds lost:**		

Patient's Signature: _____ **Date:** _____

Reviewed by: _____ **Printed Name:** _____