GASTROENTEROLOGY SPECIALISTS INC.
2726 FULTON DRIVE, N.W. • CANTON, OHIO 44718 • 330-455-5011

Questionnaire

Name: _____ Date of Birth: _____

Referring Physician: _____ Primary Physician: _____

Describe your present symptoms: _____

PAST MEDICAL HISTORY

Do you now or have you ever had: (✓Check if "yes")

- ❑ Heart Problems
- ❑ High Blood Pressure
- ❑ Rheumatic Fever
- ❑ Sleep Apnea
- ❑ Asthma
- ❑ Anesthesia/Sedation Problems
- ❑ Emphysema
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Stomach Ulcers
- ❑ Abnormal Liver Tests
- ❑ Jaundice or Hepatitis
- ❑ Colitis
- ❑ Kidney Disease
- ❑ Pneumonia
- ❑ Anemia
- ❑ HIV/AIDS
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Tuberculosis
- ❑ Osteoporosis
- ❑ Other significant Illnesses: _____

Allergies to Medications and/or Materials (i.e. Latex) describe reaction: _____

Surgical History (Type, date, hospital, surgeon): _____

List current medications and dosages: _____

SOCIAL HISTORY

Do you smoke? ❑ Yes (How many per day?)_____ ❑ No ❑ Quit (How long ago?) _____

Do you drink alcohol? ❑ Yes (How many per week?)_____ ❑ No ❑ Quit (How long ago?) _____

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use drugs for reasons that are not medical? ❑ Yes ❑ No (If yes, please list _____)

How many cups/glasses of caffeinated beverages do you drink per day? _____

Have you had any tattoos? ❑ Yes ❑ No

FAMILY HISTORY (List relatives and age who had the following)

Colon Polyps _____
Uterine Cancer _____
Intestinal or Biliary Cancer _____
Colon/rectal Cancer _____
Ovarian Cancer _____
Crohn's Disease/Ulcerative Colitis _____
Stomach Cancer _____
Pancreas Cancer _____
Esophageal Cancer _____
Barretts Esophagus _____

SYSTEMS REVIEW (Review the following list and check any problems which are or have recently affected you.)

Gastrointestinal

- ❑ Nausea/Vomiting
- ❑ Vomiting blood (coffee grounds)
- ❑ Abdominal pain
- ❑ Jaundice
- ❑ Constipation
- ❑ Persistent diarrhea
- ❑ Rectal Bleeding
- ❑ Blood in stools
- ❑ Black or tarry stools
- ❑ Change in bowel habits
- ❑ Narrow or thin stool
- ❑ Heartburn
- ❑ Acid sensation in throat or chest
- ❑ Painful swallowing
- ❑ Food sticks with swallowing

Constitutional

- ❑ Recent weight gain _____ lb.
- ❑ Recent weight loss _____ lb.
- ❑ Fatigue or weakness
- ❑ Fever
- ❑ Night sweats

Cardiovascular

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Swollen legs or feet

Respiratory

- ❑ Cough
- ❑ Wheezing (asthma)
- ❑ Shortness of breath
- ❑ Difficulty breathing at night

Initials _____ Date _____

(PLEASE CONTINUE TO BACK)

Eyes
❑ Pain or redness
❑ Loss of vision
❑ Dry or Itchy eyes

Ears–Nose–Mouth–Throat
❑ Missing or loose teeth
❑ Dentures (upper/lower?)
❑ Ringing in ears or hearing loss
❑ Sore tongue
❑ Bleeding gums or nose
❑ Sores in mouth
❑ Frequent sore throat
❑ Hoarseness

Integumentary (skin or breast)
❑ Easy bruising
❑ Redness/Rash/Hives
❑ Sun sensitive (sun allergy)
❑ Tightness
❑ Nodules/lumps

Endocrine
❑ Diabetes
❑ Thyroid disease
❑ Excessive thirst

Musculoskeletal
❑ Joint pain or swelling
❑ Muscle weakness
❑ Muscle tenderness

Hematologic/Lymphatic
❑ Anemia
❑ Bleeding tendency
❑ Transfusion (when) _____

Neurological System
❑ Headaches
❑ Dizziness or fainting
❑ Loss of consciousness
❑ Memory loss or confusion

Immunologic
Hepatitis B Vaccination ❑ Yes ❑ No
Pneumonia Shot ❑ Yes ❑ No
Flu Shot within last year ❑ Yes ❑ No

Genitourinary
❑ Pain or burning on urination
❑ Blood in urine
❑ Getting up at night to pass urine
❑ Prostate trouble

For Women Only:
Date of last period if applicable? _____
Number of pregnancies? _____
Number of miscarriages? _____
Mammogram within last 24 mo. ❑ Yes ❑ No
DXA bone scan completed ❑ Yes ❑ No
❑ Urinary incontinence

Psychiatric
❑ Excessive worries/Anxiety
❑ Depression
❑ Agitation
❑ Difficulty with sleep

Initials _____ Date _____

Are your symptoms related to any injury or illness which resulted from an automobile accident or other incident?

❑ Yes ❑ No If yes, please explain: _____

_____

Patient or family member signature: _____ Date: _____

OFFICE USE ONLY

I _____ , have reviewed this Questionnaire, and have noted changes ❑ Yes ❑ No

Signature: _____ Date: _____

I _____ , have reviewed this Questionnaire, and have noted changes ❑ Yes ❑ No

Signature: _____ Date: _____

I _____ , have reviewed this Questionnaire, and have noted changes ❑ Yes ❑ No

Signature: _____ Date: _____