## PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC. **HEALTH QUESTIONNAIRE**

PATIENT INFORMATION										
Name:		Date of Birth:			Current Age:					
Today's date:		Referring physician:								
Reason of Visit/Chief Complaint:										
Neason of visit/offici complaint.										
MEDICAL HISTORY – PAST OR PRESENT ILLNESS										
Gastrointestinal system:										
☐ Acid Reflux/GERD	☐ Peptic ulcer		☐ Helicobacter pylori		☐ Barrett's esophagus	☐ Celiac disease				
☐ Ulcerative colitis	☐ Crohn's disease		☐ Diverticulosis of colon		☐ Irritable bowel (IBS)	☐ Hemorrhoids				
☐ Colon Polyp	☐ Colon cancer		☐ Esophageal cancer		☐ Stomach cancer	☐ Liver cancer				
☐ Hepatitis A	☐ Hepatitis B		☐ Hepatitis C		☐ Fatty liver	☐ Cirrhosis of liver				
☐ Gall stones	☐ Pancreatitis		☐ Alcoholism		☐ Eating disorder	☐ Lactose intolerance				
Other systems:						15				
☐ High blood pressure	☐ Heart arte		☐ Irregular heart rhythm		☐ Heart failure	☐ Heart attack (MI)				
☐ Heart murmur	□ COPD/Em		☐ Asthma		☐ Sleep apnea	☐ Pulmonary embolism				
☐ High cholesterol/Lipid☐ Diabetes mellitus	☐ Bleeding disorder		☐ Anticoagulant therapy		☐ Anemia	☐ Deep venous clots				
☐ Osteoporosis	☐ Pre-diabe		☐ Hypothyroidism		☐ Kidney disease☐ Rheumatoid arthritis	☐ Kidney stones ☐ Spine/disc disease				
		ıa	☐ Osteoarthritis		☐ Bipolar disorder					
☐ Migraine	☐ Anxiety ☐ Stroke		<ul><li>□ Depression</li><li>□ Parkinson's disease</li></ul>		☐ HIV/AIDS	☐ Schizophrenia☐ TB/Positive PPD				
☐ Seizures☐ Basal cell skin cancer	Squamous	ckin cancar	☐ Parkinso		☐ Glaucoma	☐ Gout				
List other Illnesses:		Skiii Caricei	u iviciarioi	IIa	□ Glaucoma	□ Gout				
List other linesses.										
PREVIOUS GASTROIN	IESTINAL P	1	:5	1	□ NO	GI Procedures				
Procedure		Date(s)		Procedure		Date(s)				
☐ Colonoscopy			☐ Upper GI Endoscopy/EGD☐ Other							
☐ Sigmoidoscopy										
PREVIOUS SURGERIES	S				□ No :	Surgeries				
Surgery		Date(s)		Surgery		Date(s)				
☐ Appendectomy		2415(5)		☐ Gall bladde	r removal					
☐ Gastric bypass		☐ Laparoscop								
☐ Colon resection			☐ Exploratory,							
☐ Hemorrhoid surgery			☐ Hernia repair, g							
☐ Heart bypass surgery			☐ Heart stent(s)							
☐ Heart pacemaker				☐ Heart stent	(s)					
☐ Artificial heart valve				☐ Heart stent						
☐ Artificial heart valve				☐ AICD/defibr☐ Tonsillector	rillator ny					
☐ Artificial heart valve☐ Hip Replacement : ☐ Le				☐ AICD/defibr☐ Tonsillector	rillator					
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Patient Name:		Date of Birth:	Date of Birth:					
FAMILY HISTORY								
Relative	Colon cancer	Ulcerative colitis	Crohn's dise	ease Othe	er Disease(s)			
Father								
Mother								
Brother								
Sister								
Son								
Daughter								
Paternal grandmother								
Paternal grandfather  Maternal grandmother				+				
Maternal grandfather								
Uncle								
Aunt								
Nephew								
Niece								
No known Family history	/ of: ☐ Colon cance	er 🗆 Crohn's disea	ase 🗆 Ulcera	tive colitis    Esophagea	l cancer			
Any comment / relevant	Family history:							
REVIEW OF SYSTEMS	Please check a	nnronriate hoxes if	VOU <b>currentl</b>	y have any of these symp	ntoms			
General/Constitutional:	J. Thouse officer c	ippropriate boxes ii	you our one	y have any or these symp	nome.			
☐ Fever	☐ Tired/fatigue	☐ Loss of	appetite	☐ Recent weight loss	☐ Recent weight gain			
Gastrointestinal system:			аррошо	- Recent weight less	recom weight gain			
☐ Abdominal pain	□ Diarrhea	☐ Constipa	ation	☐ Bowel habit change	☐ Stool caliber change			
☐ Rectal bleeding	☐ Black tarry sto		continence	☐ Anal/rectal pain	☐ Anal itch			
☐ Heartburn	☐ Acid regurgitat		ive burping	☐ Nausea	☐ Vomiting			
☐ Difficulty swallowing	☐ Painful swallow			☐ Abdominal bloating	☐ Flatulence/gaseous			
Cardiovascular:								
☐ Chest pain	☐ Shortness of b	reath   Dizzine	ss/fainting	☐ Palpitations	☐ Ankle swelling			
Respiratory:								
☐ Cough	□ Wheezing	☐ Coughi	ng up blood	☐ Sleep apnea				
Eyes/ENT:	1							
☐ Blurred vision	☐ Loss of vision	☐ Sore th	roat	☐ Hoarse voice	☐ Nose bleeding			
Genitourinary/Kidneys:	T = 5			1=				
☐ Frequent urination	☐ Blood in urine	☐ Dark ur	ine	☐ Urethral discharge	☐ Impotence			
Endocrine:			to a distant	T Francisco baintena				
☐ Heat intolerance	☐ Cold intolerand	ce   L Excess	ive thirst	☐ Excessive hair loss				
Hematologic/Lymphatic:	: ☐ Excessive brui	oing Drolons	ed bleeding	☐ Swollen glands/nodes	, I			
☐ Bleeding gums  Musculoskeletal:	□ Excessive blui	sing     Prolong	led bleeding	3wollen glands/nodes	<b>o</b>			
☐ Joint pain	☐ Joint swelling	☐ Joint st	iffness	☐ Lower back pain	☐ Neck pain			
Neurological:	□ Joint Swelling	L JOHN St	1111633	Lower back pain	□ Neck pail1			
☐ Headache	☐ Fainting	□ Tinalina	/numbness	☐ Paralysis of limb(s)	☐ Seizures			
Psychiatric:	r amang		TIGITIDITOGO	- 1 draiyolo or iiiio(o)				
☐ Difficulty sleeping	☐ Excessive stres	s	tacks	☐ Suicidal thoughts	☐ Hallucination			
Skin:		1 = 1 4	140.10					
□ Rash	☐ Itching	☐ Hives		☐ Jaundice	☐ Skin lesions			
Female patients only:		1 - 1						
☐ Abnormal menses	☐ Menopause	☐ Oral cor	traceptive	☐ Currently pregnant	☐ Vaginal bleeding			
		<u> </u>	•		<u> </u>			
ADDITIONAL COMME	NTC.							
ADDITIONAL COMME	NIO.							
Signature of Patient/Guard	dian			Date				
J 2 2 2								