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:

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:				
☐ High blood pressure	☐ Heart artery disease	☐ Irregular heart rhythm	☐ Heart failure	☐ Heart attack (MI)
☐ Heart murmur	☐ COPD/Emphysema	☐ Asthma	☐ Sleep apnea	☐ Pulmonary embolism
☐ High cholesterol/Lipid	☐ Bleeding disorder	☐ Anticoagulant therapy	☐ Anemia	☐ Deep venous clots
☐ Diabetes mellitus	☐ Pre-diabetes	☐ Hypothyroidism	☐ Kidney disease	☐ Kidney stones
☐ Osteoporosis	☐ Osteopenia	☐ Osteoarthritis	☐ Rheumatoid arthritis	☐ Spine/disc disease
☐ Migraine	☐ Anxiety	☐ Depression	☐ Bipolar disorder	☐ Schizophrenia
☐ Seizures	☐ Stroke	☐ Parkinson's disease	☐ HIV/AIDS	☐ TB/Positive PPD
☐ Basal cell skin cancer	☐Squamous skin cancer	☐ Melanoma	☐ Glaucoma	☐ Gout
List other Illnesses:				

PREVIOUS GASTROINTESTINAL PROCEDURES ☐ No GI Procedures			
Procedure	**Date(s)**	**Procedure**	**Date(s)**
☐ Colonoscopy		☐ Upper GI Endoscopy/EGD	
☐ Sigmoidoscopy		☐ Other	

PREVIOUS SURGERIES ☐ No Surgeries			
Surgery	**Date(s)**	**Surgery**	**Date(s)**
☐ Appendectomy		☐ Gall bladder removal	
☐ Gastric bypass		☐ Laparoscopy	
☐ Colon resection		☐ Exploratory, abdomen	
☐ Hemorrhoid surgery		☐ Hernia repair, groin	
☐ Heart bypass surgery		☐ Heart stent(s)	
☐ Heart pacemaker		☐ AICD/defibrillator	
☐ Artificial heart valve		☐ Tonsillectomy	
☐ Hip Replacement : ☐ Left ☐ Right		☐ Knee replacement: ☐ Left ☐ Right	
☐ Hysterectomy: ☐Partial ☐Complete		☐ Caesarean section	
☐ Tubal ligation		☐ Mastectomy: ☐ Left ☐ Right	
☐ Lasik eye surgery		☐ Cataract: ☐ Left ☐ Right	
List other Surgeries and their dates:			

IMMUNIZATION HISTORY	
☐ Hepatitis B vaccination , when:	☐ Hepatitis A vaccination, when:

SOCIAL HISTORY
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Civil union ☐ Other
Children: ☐ No ☐ Yes Number: **Occupation:** ☐ Retired ☐ Disabled
Tobacco Smoking: ☐ Never smoked ☐ Quit smoking, When: _____ ☐ Current smoker: ☐ Daily ☐ Someday
Number of cigarettes per day: ☐ 0-5 ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more
Alcohol: ☐ None ☐ Quit, When: _____ ☐ Current # of drinks on a typical day: ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
Frequency: ☐ 4 or more days/week ☐ 2-3 days/week ☐ 2-4 days/month ☐ Monthly or less
Caffeine: ☐ None ☐ Coffee: _____ cups/day ☐ Tea: _____ cups/day ☐ Soda: _____ drinks/day:
Recreational Drug use: ☐ Never ☐ Quit using ☐ Currently using; DRUG: ☐ Marijuana ☐ Cocaine ☐ Other _____
Blood transfusion: ☐ No ☐ Yes, When: **Tattoo:** ☐ No ☐ Yes **Acupuncture:** ☐ No ☐ Yes

Patient Name:	Date of Birth:

FAMILY HISTORY				☐ Unknown ☐ Adopted
Relative	**Colon cancer**	**Ulcerative colitis**	**Crohn's disease**	**Other 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 cancer ☐ Crohn's disease ☐ Ulcerative colitis ☐ Esophageal cancer				
Any comment / relevant Family history:				

REVIEW OF SYSTEMS: Please check appropriate boxes if you **currently** have any of these symptoms.				
General/Constitutional:				
☐ Fever	☐ Tired/fatigue	☐ Loss of appetite	☐ Recent weight loss	☐ Recent weight gain
Gastrointestinal system:				
☐ Abdominal pain	☐ Diarrhea	☐ Constipation	☐ Bowel habit change	☐ Stool caliber change
☐ Rectal bleeding	☐ Black tarry stool	☐ Fecal incontinence	☐ Anal/rectal pain	☐ Anal itch
☐ Heartburn	☐ Acid regurgitation	☐ Excessive burping	☐ Nausea	☐ Vomiting
☐ Difficulty swallowing	☐ Painful swallowing	☐ Vomiting blood	☐ Abdominal bloating	☐ Flatulence/gaseous
Cardiovascular:				
☐ Chest pain	☐ Shortness of breath	☐ Dizziness/fainting	☐ Palpitations	☐ Ankle swelling
Respiratory:				
☐ Cough	☐ Wheezing	☐ Coughing up blood	☐ Sleep apnea	
Eyes/ENT:				
☐ Blurred vision	☐ Loss of vision	☐ Sore throat	☐ Hoarse voice	☐ Nose bleeding
Genitourinary/Kidneys:				
☐ Frequent urination	☐ Blood in urine	☐ Dark urine	☐ Urethral discharge	☐ Impotence
Endocrine:				
☐ Heat intolerance	☐ Cold intolerance	☐ Excessive thirst	☐ Excessive hair loss	
Hematologic/Lymphatic:				
☐ Bleeding gums	☐ Excessive bruising	☐ Prolonged bleeding	☐ Swollen glands/nodes	
Musculoskeletal:				
☐ Joint pain	☐ Joint swelling	☐ Joint stiffness	☐ Lower back pain	☐ Neck pain
Neurological:				
☐ Headache	☐ Fainting	☐ Tingling/numbness	☐ Paralysis of limb(s)	☐ Seizures
Psychiatric:				
☐ Difficulty sleeping	☐ Excessive stress	☐ Panic attacks	☐ Suicidal thoughts	☐ Hallucination
Skin:				
☐ Rash	☐ Itching	☐ Hives	☐ Jaundice	☐ Skin lesions
Female patients only:				
☐ Abnormal menses	☐ Menopause	☐ Oral contraceptive	☐ Currently pregnant	☐ Vaginal bleeding

ADDITIONAL COMMENTS:

Signature of Patient/Guardian

Date