EMORY CLINIC

Gastroenterology
Patient Questionnaire

Date: _____/_____/_____ Time: _____

Instructions: Please answer all questions completely and bring this with you for your clinic visit.

1. Describe briefly the chief complaint, which prompted this visit/consultation (i.e. abdominal pain, trouble swallowing, liver, problems, etc.)

2. How long have you had this problem?

3. Have you seen any previous physicians for this problem? If so, please list them.

4. Have you had previous studies to investigate this problem? If so, please describe them briefly.

5. List previous treatments or medications you have had for this problem.

6. Do you have a history of any of the following conditions? (? MEANS YOU ARE NOT SURE)

Conditions	Yes	No	?	Conditions	Yes	No	?
Abnormal liver test				Hypertension			
AIDS				Liver Disease			
Anemia				Lung Disease or Asthma			
Blood clotting problems				Pneumonia			
Other blood disorders				Rheumatic fever			
Cancer				Tuberculosis			
Diabetes				Thyroid problems			
Gallbladder problems				Ulcer Disease			
Heart Disease				Seizures or Strokes			
Heart murmur				Emotional/Psychiatric problems			
Hepatitis							

COMMENTS: _____

_____

_____

7. List any other medical conditions not mentioned above which you now have or had previously.

Problems	Year	Complications

8. Do you require antibiotics prior to having dental work? ❑ Yes ❑ No

9. Do you have any artificial heart valves, joints, or vascular prosthesis? ❑ Yes ❑ No

10. Have you ever received a blood transfusion, platelets or other blood products? If so, how much, for what reason, and when.

11. List any surgeries you've had including the hospital and surgeon, and note if there were any complications.

Surgery	Year	Hospital/Surgeon	Complications

12. Habits:

Smoking? Do you smoke now? ❑ Yes ❑ No How much per day? _____

Did you smoke previously? ❑ Yes ❑ No

How much for how long and when did you quit? _____

Alcohol? How much do you drink on an average? _____ Cocktails/beer Per day/week _____

(circle those that apply)

Have you ever been a heavy drinker? _____

Recreational Drugs? Please specify: _____

How many cups of coffee do you drink a day? _____ Tea _____

Do you use any over the counter aspirin, ibuprofen or other pain remedies? _____

Please list what and how much on an average per week: _____

13. DRUG/ALLERGIES: Please list any medications which you are allergic to and the reaction.

DRUG	ALLERGIC REACTION

14. **MEDICATIONS:** Please list all medications you take regularly.

MEDICATIONS	DOSE	TIMES PER DAY

15. **List all other medications, which you have taken in the last 6 months.**

16. **Family History:**

Father: Age now or at the time of death _____ (Indicate with "D" if deceased)
List health problems he has had _____

Mother: Age now or at the time of death _____ (Indicate with "D" if deceased)
List health problems she has had _____

Number of brothers _____
Any health problems? _____

Number of sisters _____
Any health problems? _____

Number of children _____
Any health problems? _____

Do you have any blood relatives with any of the following medical conditions?
Y=Yes N=No ? (Indicates you are not sure)

Breast Cancer _____
Chronic Heartburn _____
Colon Cancer _____
Colon polyp's _____
Chron's disease or Ulcerative Colitis _____
Diabetes _____
Emotional/psychiatric problems _____
Esophageal disorders/cancers _____
Gallbladder disease _____
Heart disease _____
High blood pressure _____
Kidney disease _____
Ovarian cancer _____
Pancreatic problems/cancer _____
Peptic ulcer disease _____
Stomach polyps/cancer _____
Strokes or seizures _____
Other cancers _____

What type of work do you do? _____

COMMENTS: _____
_____
_____

17. **REVIEW OF SYSTEMS:**
Are you now (recent) having any of the following symptoms (or have they been significant or worrisome in the past)?

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Fatigue			Heartburn		
Loss of Appetite			Reflux of stomach contents		
Weight Loss			Nausea		
Fever			Vomiting		
Chills			Abdominal pain		
Night sweats			Abdominal bloating		
Trouble with eyes, ears, nose, throat			Diarrhea		
-nosebleeds			Constipation		
-sores in mouth			Blood in stool		
-eye pain			Yellow jaundice		
Cough			Severe itching		
-dry			Difficulty voiding		
-with phlegm production			Pain with urination		
Wheezing			Male-Decreased testicular size		
Shortness of breath			-difficulty achieving erection		
-with exertion			Female-Problems with menstrual		
-with rest			-could you be pregnant		
-when lying down			-painful intercourse		
Chest pain			-irregular menstrual		
Irregular heart beat			-full term pregnancies		
Swelling in ankles			-complication with pregnancies		
Leg pain			Joint pain		
-with walking or exercise			Nervousness		
-with rest			Depression		
Bluish discoloration in hands or feet			Blackouts		
Back pain			Dizziness		
Heat and cold intolerance			Double vision		
Tremulousness of hands			Loss of balance or coordination		
Increased or decreased body hair			Difficulty speaking		
Increased thirst					
Increased urination					
Troubling swallowing					
Painful swallowing					

Thank You!!