GI History Questionnaire Today's Date: ____/____/____

Full Name: _____ **DOB:** _____/_____/_____ **Age:** _____

Referring Physician: _____ **Primary Care Physician:** _____

Current Medications

Prescription Medications

❑ I do not take prescription medications

Prescription Medications (Ex. Atenolol)	Dose/Strength (Ex. 50mg)	Directions (Ex. Twice a Day)	Reason (Ex. Blood pressure)

Over the Counter Medications

❑I do not take over the counter medications

Over the Counter Medications (Ex. Tylenol)	Dose/Strength (Ex. 25 mg)	Directions (Ex. As Needed)	Reason (Ex. Headaches)

Herbs/Vitamins/Minerals

❑I do not take any herbs/vitamins/minerals

Herbs/Vitamins/Minerals (Ex. Fish Oil)	Dose/Strength (Ex. 10 mg)	Directions (Ex. Once a Day)	Reason (Ex. Blood Pressure)

Allergies

❑No Known Allergies

Medication/Food Allergies			Type of Reaction (Ex. Rash, stomach upset, headache)
Penicillins?	❑No	❑ Yes	
Latex?	❑No	❑ Yes	
Sulfa Drugs?	❑No	❑ Yes	

Social History

Occupation: _____ Hobbies: _____

Do you use tobacco?	❑Never	❑Yes_____ packs per day for _____ years	❑Quit, Approx. Date_____
Do you drink alcohol?	❑No	❑Social drinker (rarely) ❑2 or less/day ❑3 or greater/ day	
Do you use recreational drugs?	❑No	❑Yes, type: _____ ❑Occasionally ❑Weekly ❑Daily	
History of alcohol abuse?	❑No	❑Yes _____years	
History of drug abuse?	❑No	❑Yes _____years	

Past Medical History

Please check the box if you have any of the following conditions ❑ No History

❑Anemia	❑ Anxiety	❑ Arthritis	❑Asthma
❑ Atrial Fibrillation	❑Autoimmune Disorder: Type? _____	❑Bleeding Disorder: Type? _____	❑ Taking Blood Thinners (Plavix, Warfarin, Aspirin, etc.)
❑ Blood Transfusion	❑Cancer: Type? _____	❑ Chest Pain	❑ COPD
❑Chronic Pain: Location of Pain _____	❑ Colitis: Type? _____	❑ Colon Polyps	❑ Congestive Heart Failure
❑ Constipation	❑ Crohn's Disease	❑ Diabetes	❑ Defibrillator
❑ Diverticulitis	❑ Diverticulosis	❑ GERD/Heartburn	❑ Glaucoma
❑Heart Attack	❑ Heart Disease	❑ Heart Murmur	❑ Hemorrhoids
❑ Hepatitis: ❑A ❑B ❑C	❑Hernia: Type? _____	❑ Home Oxygen Use	❑ Hyperlipidemia
❑ Hypertension	❑ Hyperthyroidism	❑ Hypothyroidism	❑Irritable Bowel Syndrome
❑ Kidney Stones	❑ Kidney Disease	❑ Liver Disease, Type? _____	❑ Migraines
❑Multiple Sclerosis	❑ Pacemaker	❑ Parkinson's Disease	❑Peptic Ulcer Disease
❑PTSD	❑ Seizures	❑ Sexual Abuse	❑ Sleep Apnea: ❑Using CPAP/BiCap
❑ Stroke	❑TIA (Mini-Stroke)	❑ Tuberculosis	

Review of Systems

Please check the box if you have any of the following symptoms ❑ No Symptoms

Constitutional	❑ Weight Change ❑ Fevers ❑ Chills ❑Feeling Tired
Head	❑ Headache ❑ Head Trauma
Eyes	❑ Blindness ❑Wearing Glasses
Ear/Nose/Throat	❑ Hearing Loss ❑ Snoring ❑ Throat Pain ❑ Hoarseness ❑ Mouth Sores
Cardiovascular	❑ Chest Pain ❑ Fast Heart Rate ❑ Palpitations
Lung	❑ Shortness of Breath ❑ Cough ❑ Coughing up Blood ❑ Wheezing
Genitourinary	❑ Painful Urination ❑ Blood in Urine ❑ Pregnant?
Musculoskeletal	❑ Joint Pain ❑ Joint Stiffness
Skin	❑ Infection
Gastrointestinal	❑ Change in Appetite ❑ Belching ❑ Gagging ❑ Regurgitation ❑ Feeling Full ❑ Bloating ❑ Vomiting up Blood ❑ Difficulty Swallowing ❑ Heartburn ❑ Nausea ❑ Gas ❑Diarrhea ❑ Vomiting ❑ Abdominal Pain ❑ Jaundice ❑ Constipation ❑ Change in Bowel Frequency ❑ Change in Bowel Habits ❑ Bright Red Blood From the Rectum ❑ Rectal Pain
Neurological	❑ Tremors ❑ Weakness ❑ Numbness and Tingling
Metabolic	❑ Excessive Sweating ❑ Excessive Thirst ❑ Intolerant to Cold ❑ Intolerant to Heat
Blood	❑ Past Blood Transfusion ❑ Taking Blood Thinners
Infectious	❑ Recent Foreign Travel ❑ Hepatitis ❑ HIV/AIDS ❑ Sexually Transmitted Disease
Psychological	❑ Sleep Disturbance ❑ Anxious ❑ Depressed ❑ PTSD ❑ Sexual Abuse

Previous Surgeries	❑No Surgeries
Type of Surgery	**Approximate Date/Year**

Previous Anesthesia Reactions	❑No History
❑Self	**❑Family Member:** ❑Mother ❑Father ❑Sibling--❑M ❑F ❑Child--❑M❑F ❑Other: _____❑Mother's Side ❑Father's Side
Reaction: ❑Nausea/Vomiting ❑High Fever ❑Other:_____	**Reaction:** ❑Nausea/Vomiting ❑High Fever ❑Other:_____

Previous Endoscopic Procedures			❑No Procedures
Type of Procedure	**Date**	**Where**	**Findings**
❑Colonoscopy			❑Normal ❑Abnormal: _____
❑Upper Endoscopy/EGD			❑Normal ❑Abnormal: _____
❑Flexible Sigmoidoscopy			❑Normal ❑Abnormal: _____
❑GI Related Studies (Barium Swallow, etc.) Type? _____			❑Normal ❑Abnormal: _____

Family Medical History						
Colon Cancer	❑Mother Age_____	❑Father Age____	❑Sibling ❑M Age_____ ❑F	❑Child ❑M Age____ ❑F	❑Other: _____ Age_____ ❑Mother's Side ❑Father's Side	❑None
Colon Polyps	❑Mother Age_____	❑Father Age____	❑Sibling ❑M Age_____ ❑F	❑Child ❑M Age____ ❑F	❑Other: _____ Age_____ ❑Mother's Side ❑Father's Side	❑None
Gastrointestinal Disorder (Crohn's, Celiac, etc.) **Type?** _____	❑Mother Age_____	❑Father Age____	❑Sibling ❑M Age_____ ❑F	❑Child ❑M Age____ ❑F	❑Other: _____ Age_____ ❑Mother's Side ❑Father's Side	❑None
Breast Cancer	❑Mother Age_____	❑Father Age____	❑Sibling ❑M Age_____ ❑F	❑Child ❑M Age____ ❑F	❑Other: _____ Age_____ ❑Mother's Side ❑Father's Side	❑None
Cervical Cancer	❑Mother Age_____		❑Sister Age_____	❑Child ❑M Age____ ❑F	❑Other: _____ Age_____ ❑Mother's Side ❑Father's Side	❑None
Ovarian Cancer	❑Mother Age_____		❑Sister Age_____	❑Child ❑M Age____ ❑F	❑Other: _____ Age_____ ❑Mother's Side ❑Father's Side	❑None
Uterine Cancer	❑Mother Age_____		❑Sister Age_____	❑Child ❑M Age____ ❑F	❑Other: _____ Age_____ ❑Mother's Side ❑Father's Side	❑None
Other: _____	❑Mother Age_____	❑Father Age____	❑Sibling ❑M Age_____ ❑F	❑Child ❑M Age____ ❑F	❑Other: _____ Age_____ ❑Mother's Side ❑Father's Side	❑None
Other: _____	❑Mother Age_____	❑Father Age____	❑Sibling ❑M Age_____ ❑F	❑Child ❑M Age____ ❑F	❑Other: _____ Age_____ ❑Mother's Side ❑Father's Side	❑None

Physician Signature: _____

****Please bring this with you to your appointment****