MITTAL
Gastroenterology & Rheumatology

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# PATIENT QUESTIONNAIRE

**Date:** _____ **Name:** _____ **DOB:** _____

Reason for Visit: ☐ Colonoscopy ☐ Upper Endoscopy ☐ Office Visit for: _____

**Height** _____ **Weight** _____

Do any of the following apply to you? ☐ None

☐ **Pacemaker** ☐ **Defibrillator** ☐ **Home Oxygen**

☐ **Kidney Dialysis** ☐ **Blood Thinners (Such as Coumadin, Plavix, Aggrenox) If Yes, Cardiologist Name** ____

SYSTEM REVIEW: Do you experience any of the following: None

| | | | | | |
|---|---|---|---|---|---|
| ☐ Weight Loss | ☐ Rash | ☐ Short of Breath | ☐ Chest Pain | ☐ Rhinitis | ☐ Abdominal Pain |
| ☐ Fevers | ☐ Lumps | ☐ Cough | ☐ Palpitations | ☐ Hay Fever | ☐ Change in Appetite |
| ☐ Chills | ☐ Sores | ☐ Coughing Blood | ☐ Fainting | ☐ Hives | ☐ Difficulty Swallowing |
| ☐ Night Sweats | ☐ Nail Changes | ☐ Wheezing | ☐ Easy Bruising | ☐ + TB Test | ☐ Change in Bowel Habits |
| ☐ Fatigue | ☐ Sore Throat | ☐ Excess Thirst | ☐ Easy Bleeding | ☐ Heartburn | ☐ Blood in Stool |
| ☐ Joint Pain | ☐ Hoarseness | ☐ Excess Sweating | ☐ Swollen Glands | ☐ Nausea | ☐ Painful Bowels |
| ☐ Muscle Pain | ☐ Bloody Nose | ☐ Cold Intolerance | ☐ Blood in Urine | ☐ Vomiting | ☐ Yellow eye/skin |
| ☐ Muscle Weakness | ☐ Hearing Loss | ☐ Heat Intolerance | ☐ Burning w/ Urination | ☐ Diarrhea | ☐ Hemorrhoids |
| ☐ Joint Swelling | ☐ Bleeding Gums | ☐ Leg Swelling | ☐ UTI's | ☐ Constipation | |

**Provide details/list other symptoms:** _____

**PAST MEDICAL HISTORY:** Have you had any of the following diseases: ☐ None

| | | | | |
|---|---|---|---|---|
| ☐ Ulcers | ☐ Diabetes | ☐ High Blood Pressure | ☐ Stroke | ☐ Bleeding Disorder |
| ☐ GI Bleeding | ☐ High Cholesterol | ☐ Heart Attack | ☐ Seizure | ☐ Blood Clots |
| ☐ Anemia | ☐ Asthma | ☐ Heart Failure | ☐ Rheumatic Fever | |
| ☐ Hepatitis A, B, or C | | ☐ Mitral Valve Prolapse | ☐ Kidney Disease | |
| ☐ Atrial Fibrillation | | ☐ Gout | | |

☐ Cancer (specify : _____)

**PAST SURGICAL HISTORY**: If you have had any of the follow surgeries, list date and type if any. ☐ None

| | | | |
|---|---|---|---|
| ☐ Gallbladder | Date: _____ | ☐ Appendix | Date: _____ |
| ☐ Stomach | Date: _____ | ☐ Hysterectomy | Date: _____ |
| ☐ Appendix | Date: _____ | ☐ Heart Bypass | Date: _____ |
| ☐ Hernia | Date: _____ | ☐ Transplantation | Date: _____ |
| ☐ Colon | Date: _____ | ☐ Heart/Artery/Stent | Date: _____ |
| ☐ Other: | Date: _____ | | |

**PAST ENDOSCOPIC HISTORY**: What prior endoscopies have you had? ☐ None

| | | |
|---|---|---|
| ☐ Upper Endoscopy | Date: _____ | Results: _____ |
| ☐ Colonoscopy | Date: _____ | Results: _____ |

☐ **I am a returning patient; please see my chart for previous procedures**

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**FAMILY MEDICAL HISTORY**: Which cancers run in your family? Please specify family member below. ☐ None

☐ Esophagus ☐ Stomach ☐ Pancreas ☐ Colon ☐ Liver ☐ Breast ☐ Uterine ☐ Ovarian ☐ Gallbladder

Specify Family Member: _____ Age at Diagnosis:_____

**Other Diseases:** ☐ GI Ulcers ☐ Pancreatitis ☐ Colon Polyps ☐ Colitis ☐ Reflux (GERD) ☐ Bleeding Tendency
☐ Diverticular Disease ☐ Crohn's Disease ☐ Irritable Bowel Syndrome (IBS)

Specify Family Member: _____ Age at Diagnosis:_____

**SOCIAL HISTORY:**

☐ Single ☐ Married ☐ Partner ☐ Widowed ☐ Divorced Number of Children: _____ Ages: _____

☐ Occupation (current or previous) _____ ☐ Retired ☐ Disabled

Tobacco: ☐ Never ☐ Quit Date: _____ ☐ Still Smoking

No. of years smoked? _____ How much **per day?** _____

Alcohol: ☐ None ☐ Beer ☐ Wine ☐ Mixed Drinks **How much per week?** _____

**DRUG ALLERGIES**: ☐ None ☐ Contrast Agent ☐ Antibiotics (please specify) ☐ Other (please specify)

_____

**MEDICATIONS:** ☐ No ☐ Yes **Please list all the medications that you currently take. This information is vital to your office visit or procedure with our practice.**

| MEDICATION NAME/DOSE | FREQUENCY |
|---|---|
| _____ | ☐Daily ☐ Twice a day ☐ As Needed |
| _____ | ☐Daily ☐ Twice a day ☐ As Needed |
| _____ | ☐Daily ☐ Twice a day ☐ As Needed |
| _____ | ☐Daily ☐ Twice a day ☐ As Needed |
| _____ | ☐Daily ☐ Twice a day ☐ As Needed |
| _____ | ☐Daily ☐ Twice a day ☐ As Needed |
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| _____ | ☐Daily ☐ Twice a day ☐ As Needed |
| _____ | ☐Daily ☐ Twice a day ☐ As Needed |