East Side Endoscopy, LLC
Patient History Questionnaire

Name:_____ Date:_____

Reason for Visit:_____ Age:_____

Past Medical History:

General:

Diabetes	No	Yes
High Blood Pressure	No	Yes
Thyroid Disease	No	Yes
High Cholesterol	No	Yes
Arthritis	No	Yes
Anemia	No	Yes
Scleroderma	No	Yes
Cancer Type:	No	Yes

Heart:

Heart attack	No	Yes
Congestive heart failure	No	Yes
Bypass surgery	No	Yes
Cardiac stents	No	Yes
Valve disease	No	Yes
Artificial Heart Valve	No	Yes
Atrial Fibrillation	No	Yes
Permanent pacemaker	No	Yes
Implantable defibrillator	No	Yes

Lungs:

Asthma	No	Yes
Emphysema	No	Yes
Pneumonia	No	Yes
Sleep apnea	No	Yes
Blood clot	No	Yes
Tuberculosis	No	Yes

Urologic/Gynecologic:

Renal failure/insufficiency	No	Yes
Kidney stones	No	Yes
Prostate problems	No	Yes
Uterine fibroids	No	Yes
Ovarian cysts	No	Yes
Endometriosis	No	Yes

Gastrointestinal:

Acid reflux	No	Yes
Helicobacter pylori	No	Yes
Stomach ulcers	No	Yes
Diverticulitis	No	Yes
Irritable bowel syndrome	No	Yes
Crohn's Disease	No	Yes
Ulcerative colitis	No	Yes
Colon polyps	No	Yes
Colon cancer	No	Yes
Hemorrhoids	No	Yes
Hepatitis/Liver disease	No	Yes
Parasites	No	Yes

Neurologic/Other:

Stroke	No	Yes
Seizures	No	Yes
Anxiety/depression	No	Yes
Alzheimer's Disease	No	Yes
Parkinson's Disease	No	Yes
Alcoholism	No	Yes
Drug abuse	No	Yes
Eating disorder	No	Yes

Other Medical Problems:_____

_____

_____

Surgery:

Appendix removed	No	Yes
Gallbladder removed	No	Yes
Stomach surgery	No	Yes
Colon surgery	No	Yes
Uterus removed	No	Yes
Ovaries removed	No	Yes
Artificial joints	No	Yes
Other:		

Past GI Testing: **When:**

Upper Endoscopy	No	Yes	____ ____ ____ ____ ____ ____
Sigmoidoscopy	No	Yes	____ ____
Colonoscopy	No	Yes	____ ____ ____ ____ ____ ____

Social History:

Tobacco	No	Yes	Amount:	
Alcohol	No	Yes	Amount:	
Caffeine	No	Yes	Amount:	
Illicit Drugs	No	Yes	Amount:	
Marital Status	Single	Married	Divorced	Widow(er)
Children	#	Ages:		
Occupation				

Family History:			Relationship to you/Age at diagnosis:
Colon polyps	No	Yes	
Colon cancer	No	Yes	
Crohn's Disease	No	Yes	
Ulcerative Colitis	No	Yes	
Celiac Disease	No	Yes	
Esophageal cancer	No	Yes	
Stomach cancer	No	Yes	
Pancreatic cancer	No	Yes	
Liver disease/Hepatitis	No	Yes	
Bleeding disorders	No	Yes	
Other cancers	No	Yes	
Cause of death in parents (if applicable)			

Please circle any Gastrointestinal symptoms/signs that apply:

Poor appetite	Heartburn/regurgitation	Diarrhea	Black or tarry stool
Nausea/vomiting	Indigestion	Rectal pain	Abnormal G.I. series
Abdominal Pain	Change in bowel habits	Stool incontinence	Abnormal CT scan
Abdominal bloating	Constipation	Hidden blood in stool	Abnormal ultrasound
Difficulty swallowing liquids	Difficulty swallowing solids	Rectal bleeding	Abnormal liver enzymes

Do you have any of the following symptoms/signs (please circle):

Weight loss	Shortness of breath	Joint aches	Anemia
Fatigue	Cough	Hearing problems	Low platelets
Lightheadedness	Rash	Visual problems	Bleeding/bruising
Fever/chills	Itching	Leg/feet swelling	Nosebleeds
Headaches	Frequent urination	Vertigo	Nightsweats
Memory loss	Blood in urine	Genital/gyn problems	Other:
Chest pain	Urine incontinence	Difficulty sleeping	
Throat clearing	Muscle aches	Hoarseness	

Medications: (including over-the-counter)

Name	Dose	Name	Dose

		Aspirin	No Yes
		Ibuprofen (advil,aleve,etc)	No Yes
		Coumadin (warfarin)	No Yes
		Plavix (clopidogrel)	No Yes
		Persantine (dipyridamole)	No Yes
		Ticlid (ticlopidine)	No Yes

Allergies to Medications: **Are you allergic to:**

		Latex	No	Yes
		Anesthesia	No	Yes
		IV dye/iodine	No	Yes
		Soy/eggs	No	Yes
		Penicillin	No	Yes
		Other:		

Patient Signature:_____ **Date:**_____

Questionnaire reviewed by Physician:_____ **Date:**_____