Atlanta Gastroenterology Specialists P.C.
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Digestive Care Patient Questionnaire

Patient Name:_____ **Date:**_____

It is very important that your physician has current and accurate information in order for him to provide you with the best medical care available. Please take your time in answering the following questions.

Requesting Physician:_____

Primary Care Physician:_____

My Chief Complaint is:_____

I was referred here for:_____

Present Medications/ Dose Please List ALL	**ALLERGIES**

Have you been on Steroids/ 6MP or Azathiprine ? If so how long and how much

_____

Have you ever been on Remicade,Humira or Cimzia? If so which med ,when and how long did you take the medication_____

_____

Indicate if you have had *any* of the following GI Procedures and approximate date (months/years ago) --and findings, if known.

Exam	Exam Date	Findings:
☐ **Colonoscopy**		
☐ EGD (Endoscopy)		
☐ Capsule Endoscopy		
☐ ERCP		
☐ CT SCAN		
☐ Ultrasound		
☐ UGI Series		
☐ Small Bowel Series		
☐ Barium Enema		
☐ MRI		
☐ **Other:**		
☐ Other:		

Indicate if ***you*** **presently have** or **have been treated** for *any* of the following gastrointestinal conditions

☐ Barrett's Esophagus	☐ Gastritis
☐ Upper GI Bleeding	☐ Gallbladder Disease
☐ Rectal Bleeding	☐ Hepatitis Type
☐ Colon Polyps	☐ Hiatal Hernia
☐ **Colon Cancer When?**	☐ Irritable Bowel Syndrome
☐ Constipation	☐ Liver Disease
☐ **Crohn's Disease Location_____**	☐ Ulcer Disease (Gastric or Peptic)
☐ Diverticulosis	☐ **Ulcerative Colitis**
☐ Esophageal Reflux	**OTHER**

Indicate if you **presently have** or **have been treated** for *any* of the following general medical conditions **Please be Specific**

☐ Anemia	☐ Diabetes Mellitus
☐ Asthma	☐ HIV
☐ Atrial Fibrillation	☐ Hyperlipidemia
☐ **Cancer TYPE/Location**	☐ Hypertension
	☐ Kidney Disease
☐ COPD	☐ Neurologic Disorders
☐ Congestive Heart Failure	☐ Thyroid Disorders
☐ Coronary Artery Disease/Heart Attack	☐ Valvular Heart Disease

ALL OTHER Med Conditions

_____

_____

_____

Indicate if you **have had any** of the following surgeries and approximate date

Surgery	Date	Surgery	Date
☐ Appendectomy		☐ Coronary Artery Bypass Graft	
☐ Biliary Surgery		☐ Heart Valve Replacement	
☐ Fistula Surgery		☐ Hernia Repair	
☐ Colon Polyps		☐ Inguinal Hernia Repair	
☐ Colon Resection Partial		☐ Pacemaker Placement	
☐ Hemorrhoidectomy		☐ Ovaries removed	
☐ Gastric Surgery		☐ Tonsils-Adenoids	
☐ Small Bowel Resection		☐ TURP	
☐ Ulcer Surgery		☐ Prostate Radiation seeds	
☐ Gastric Bypass		☐ Gastric Lap Band	
☐ Gall Bladder Removal		☐ Other:	

Indicate if anyone in your **immediate family** has had any of the following diseases

Diagnosis	Relationship	Diagnosis	Relationship
Breast Cancer		Diabetes	
Colon Cancer		Early Death	
Colon Polyps		Heart Disease	
Ovarian Cancer		Hepatitis	
Prostate Cancer		Hypertension	
Cancer - Other		Liver Disease	
Depression		Thyroid Disorder	

Social Information & History

Occupation:	_____			
Current Status:	☐ Single	☐ Married	☐ Widowed	☐ Divorced
Alcohol Use:	☐ Yes ☐No	If yes, frequency: _____	How much: _____	
Caffeine Use	☐ Yes ☐No	If yes, frequency: _____	How much: _____	
Smoking	☐ Yes ☐No	_ packs / day -----cigarettes / day	When did you quit?	
Recreational Drug Use	☐ Yes ☐No			
Influenza Vacc	When_____	**PNEUMOVAX Vaccine**	When_____	
Exercise Habits	How often?	_____	What type?	_____

Indicate if you presently have or are being treated for any of the following symptoms:

General
Chills _____
Fever _____
Night Sweats _____
Feeling tired or poorly (malaise) _____
Other (weight gain / loss)

Head Symptoms
Headache _____
Facial pain _____
Sinus pain _____
Other head symptoms _____

Eye Symptoms _____
Worsening vision _____
Blurred vision _____
Vision distortion _____
Other eye symptoms

Otolaryngeal Symptoms
Earache _____
Nosebleeds (epistaxis) _____
Nasal discharge _____
Mouth sores _____
Bleeding gums _____
Hoarseness _____
Throat pain

Neck Symptoms
Neck pain _____
Neck stiffness _____
Lump or swelling in neck area _____
Other neck symptoms

Cardiovascular symptoms
Chest pain or discomfort _____
Fast heart rate _____
Palpitations _____
Other cardiovascular symptoms _____
_____

Pulmonary Symptoms
Shortness of breath _____
Cough _____
Coughing up blood (hemoptysis) _____
Wheezing _____
Other Pulmonary symptoms _____

Genitourinary Symptoms
Dysuria-burning, difficulty urinating _____
Increased urinary frequency _____
Hematuria (blood in urine) _____
Other: _____

Female (GYN)
Vaginal bleeding _____
Vaginal discharge _____
Vaginal pain during intercourse _____
_____

Skin Symptoms _____
Pruritus (itching) _____
Skin lesions _____
Rashes _____
Other skin symptoms:

Stool Description if abnormal
Change in stool color _____
Change in stool character _____
Size of the stool has changed _____
Consistence of the stool has changed _____
Foul smelling _____
Diarrhea _____
Other GI symptoms

Musculoskeletal Symptoms
Joint pain, localized _____
Joint stiffness, localized _____
Muscle aches _____
Low back pain

Neurological Symptoms
Dizziness _____
Vertigo _____
Fainting (syncope) _____
Motor disturbances _____
Sensory disturbances _____

Psychological Symptoms
Sleep disturbances _____
Anxiety _____
Depression _____
Other psychological symptoms: _____

None of the above apply to me _____ Signature_____ DATE_____