

Cary Gastroenterology Associates Health Questionnaire

Please complete the entire Questionnaire

NAME: _____ DOB: _____ Today's Date: _____

Reason for visit: _____

Referring MD(s): _____ Primary Care Provider: _____

Current Pharmacy (name and location) _____

Contact Preference Letter Telephone Call

DRUG ALLERGIES

- None
- Demerol Novacain Penicillins Sulfa (Sulfonamides) Aspirin
- Morphine Valium Other _____
- Egg Soy Other _____
- Are you allergic to Latex? No Yes If yes Severe reaction Mild reaction
- Do you require antibiotics for routine dental cleaning? Yes No
- Do you have problems with anesthesia? Yes No

Past or Present Medical Conditions

- None
- Cardiac**
- Heart Murmurs High Blood Pressure High Cholesterol Irregular Heartbeat
- Mitral Valve Prolapse/MR Angina Heart Attack/MI Congestive Heart Failure
- Heart Stents Pacemaker/Defibrillator Atrial Fibrillation

Pulmonary

- Asthma Emphysema C.O.P.D. Sleep Apnea on CPAP
- Sleep Apnea on No CPAP Other chronic lung disease

GI

- Acid Reflux Gerd Barrett's Esophagus Ulcerative Colitis
- Other Collitis Crohn's Disease Colon Polyps Ulcers
- Diverticular Disease Colon Cancer Fatty Liver Gallstones
- Gallbladder Dysfunction Celiac Disease IBS Cirrhosis
- Hiatal Hernia H. Pylori Infection Hemorrhoids Bowel Obstruction
- Milk/Lactose Intolerance

Kidney/ Urinary

- Urinary Incontinence BPH (enlarged prostate) Kidney stones Kidney failure
- Other Kidney Disease

Endocrine

- Diabetes Mellitus Thyroid Disease Osteoporosis

Neurologic/Musculoskeleton/Rheumatologic

- Stroke
- TIA
- Parkinson's
- Migrains
- Fibromyalgia
- Seizures
- Arthritis
- Dementia
- Lupus

Psychological

- Depression
- Anxiety Disorder
- Bipolar Disorder
- ADD/ADHD
- Schizophrenia

Gynecologic

- Endometriosis
- Uterine Fibroids
- Ovarian Cyst

Miscellaneous

- Anemia
- Bleeding Disorder
- Obesity
- Glaucoma
- Cataracts
- Eating Disorder

Cancer

- Lung Cancer
- Breast Cance
- Prostate Cancer
- Cervical Cancer
- Ovarian Cancer
- Skin Cancer
- Skin Cancer (non melanoma)
- Uterine Cancer
- Stomach Cancer
- Esophageal Cancer
- Pancreatic Cancer
- Brain Cancer

Previous Surgeries/Procedures:

- None

Surgical History

- Adhesions
- Endometriosis
- Ovary Surgery
- Arthroscopy
- Hernia Repair
- Joint Replacement
- Back/Neck Surgery
- C-Section
- Cariac Stents
- Cardiac Bypass
- Heat Valve Surgery
- Lasik
- Kidney Stone Surgery
- Prostrate Surgery
- Organ Transplant
- Thyroid Surgery
- Tonsillectomy
- Hysterectomy

GI Surgical History

- Colonoscopy
- Endoscopy
- ERCP
- Colostomy Bag
- Gastric Bypass/Obesity Surgery
- Liver B Biopsy
- Ulcer Surgery
- Whipple Procedure
- Anti-Reflux Surgery
- Appendectomy
- Gallbladder Removal
- Bowel Obstruction Surgery
- Other _____

Cancer Surgery

- Breast Cancer
- Colon Cancer
- Prostate Cancer
- Cervical Cancer
- Pancreatic Cancer
- Ovarian Cancer
- Uterine Cancer
- Esophageal Cancer
- Stomach Cancer
- Skin Cancer
- Other Cancer _____

Social History

Marital Status: Single Separated Married Divorced Widowed

Number of children: _____

Exercise: I do not exercise I do exercise

Alcohol Use: Never Rarely Daily More than 2 days per week
 Less than 2 days per week I quit using alcohol

Tobacco Use: I use tobacco products
 I have never used tobacco products
 I quit using tobacco products

Caffeine None
 Caffeine Soft Drinks Tea Chocolate Other _____

Drug Use None
Type: _____ Quantity: _____ Frequency: _____

List Occupation: _____

Military Veteran: Yes No

Review of Systems

Gastrointestinal

- | | | |
|--|---|---|
| <input type="radio"/> None | <input type="radio"/> Dairy Intolerance | <input type="radio"/> Mucous in Stool |
| <input type="radio"/> Abdominal Pain | <input type="radio"/> Diarrhea | <input type="radio"/> Nausea |
| <input type="radio"/> Belching | <input type="radio"/> Difficulty Swallowing | <input type="radio"/> Pain w/Bowel Movement |
| <input type="radio"/> Black Stools | <input type="radio"/> Flatulence | <input type="radio"/> Rectal Bleeding |
| <input type="radio"/> Bloating | <input type="radio"/> Heartburn | <input type="radio"/> Rectal Urgency |
| <input type="radio"/> Change in bowel habits | <input type="radio"/> Hemorrhoids | <input type="radio"/> Soiling Stool |
| <input type="radio"/> Constipation | <input type="radio"/> Jaundice | <input type="radio"/> Vomiting |
- other: _____

Urinary

- None
- Kidney disease/failure
- Frequent urinary infections
- Change in urinary frequency
- Sexually Transmitted Disease
- Blood in urine
- Kidney Stones
- Other _____

Male

- Testicle Problem

Female

- Heavy Periods
- Breast Lump

Skin

- None
- Dryness
- Hives
- Itching
- Lesions
- Rashes
- Other: _____

Cardiovascular

- | | |
|--------------------------------------|---|
| <input type="radio"/> None | <input type="radio"/> Shortness of Breath with exercise |
| <input type="radio"/> Chest Pain | <input type="radio"/> Irregular Heartbeat/Pulse |
| <input type="radio"/> Palpitations | <input type="radio"/> Shortness of breath when laying flat |
| <input type="radio"/> Ankle Swelling | <input type="radio"/> Abnormal stress test/ekg/echo/catherization |
| <input type="radio"/> Other _____ | |

Neurological

- None
- Dizziness
- Frequent Headaches
- Numbness in Extremities
- Other _____

Endocrine

- None
- Excessive thirst
- Hair loss
- Cold Intolerance
- Poor blood sugar control
- Other _____

Constitutional

- None
- Fever
- Loss of Appetite
- Fatigue
- Weight gain
- Weight loss
- Flushing
- Other _____

Psychiatric

- None
- Anxiety/Panic
- Depression
- Difficulty Sleeping
- Inability to Concentrate
- Other _____

Eyes

- None
- Eye Pain
- Night Sensitivity
- Visual Decline
- Glasses/ contacts
- Other _____

Hematologic

- None
- Easy Bruising
- Prolonged Bleeding
- Swollen Glands
- Other _____

Ears, Nose & Throat

- None
- Nose Bleeds
- Sore Throat
- Hearing Loss
- Cough
- Other _____

Musculoskeletal

- None
- Back Pain
- Joint Pain
- Muscle Pain
- Trouble walking/standing
- Other _____

Respiratory

- None
- Cough
- Wheezing
- Coughing up blood
- Other _____

Immunologic

- None
- Allergies
- Immune Deficiency
- HIV-AIDS illness
- Night Sweats
- Other _____

Family History**Father****Mother****Children****Brothers****Sisters****Grandparents**

No Knowledge of family history

No family history of colon cancer colon polyps

Healthy

Deceased (age)
cause of death

Alcoholism

Rheumatoid Arthritis

Autoimmune Disease

Bleeding Tendency

Breast Cancer

