

# SAN FRANCISCO GASTROENTEROLOGY

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## PATIENT QUESTIONNAIRE:

Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for Visit:  Pre Colonoscopy  Pre Upper Endoscopy  Office Visit for: \_\_\_\_\_

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

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

Provide details/list other symptoms:

\_\_\_\_\_

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

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Stroke          | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> GI Bleeding          | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Seizure         | <input type="checkbox"/> Blood Clots       |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Heart Failure         | <input type="checkbox"/> Rheumatic Fever |  |
| <input type="checkbox"/> Hepatitis A, B, or C |  | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Kidney Disease  |  |
| <input type="checkbox"/> Gout                 | <input type="checkbox"/> Cancer (specify: _____) |  |  |  |

**PAST SURGICAL HISTORY:** What operations have you had?  None

- |                                      |             |  |             |
|--------------------------------------|-------------|--|-------------|
| <input type="checkbox"/> Gallbladder | Date: _____ | <input type="checkbox"/> Appendix        | Date: _____ |
| <input type="checkbox"/> Stomach     | Date: _____ | <input type="checkbox"/> Hysterectomy    | Date: _____ |
| <input type="checkbox"/> Appendix    | Date: _____ | <input type="checkbox"/> Heart Bypass    | Date: _____ |
| <input type="checkbox"/> Hernia      | Date: _____ | <input type="checkbox"/> Transplantation | Date: _____ |
| <input type="checkbox"/> Colon       | Date: _____ | <input type="checkbox"/> Other:          | Date: _____ |

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

- |  |             |                |
|--|-------------|----------------|
| <input type="checkbox"/> Upper Endoscopy | Date: _____ | Results: _____ |
| <input type="checkbox"/> Colonoscopy     | Date: _____ | Results: _____ |
| <input type="checkbox"/> ERCP            | Date: _____ | Results: _____ |

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

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

**Cancers:**  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: \_\_\_\_\_

**STAFF ONLY:** NP/FP CURRENT DOS: \_\_\_\_\_ NO CHANGE FROM LAST DOS: \_\_\_\_\_

PATIENT INITIAL: \_\_\_\_\_ STAFF INITIAL: \_\_\_\_\_ MD SIGNATURE: \_\_\_\_\_

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## 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)

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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  
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**STAFF ONLY:** NP/FP CURRENT DOS: \_\_\_\_\_ NO CHANGE FROM LAST DOS: \_\_\_\_\_

PATIENT INITIAL: \_\_\_\_\_ STAFF INITIAL: \_\_\_\_\_ MD SIGNATURE: \_\_\_\_\_