Pinehurst Medical Clinic

Pinehurst Medical Clinic Gastroenterology Patient Questionnaire

Name: _____Age: _____Date: _____

Visit Reason: _____

Please Check Box for Any Medical Conditions:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Cancer
- ☐ COPD/Emphysema
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Heart Trouble
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid

Other Conditions: _____

Please Check Box for Prior Surgeries/Procedures (please include endoscopy procedures):

- ☐ Appendix
- ☐ Back Surgery
- ☐ Colonoscopy
- ☐ Colon Surgery
- ☐ C-section
- ☐ Gallbladder
- ☐ Heart Bypass
- ☐ Heart Valve
- ☐ Hernia
- ☐ Hip Replaced
- ☐ Hysterectomy (uterus removed)
- ☐ Knee Replaced
- ☐ Tonsils
- ☐ Upper Endoscopy

Other Surgeries: _____

Family Medical History

List any medical problems that run in your family and who had them:

_____

Has anyone in your family had uterine, ovarian, and/or colon cancer? ☐ Yes ☐ No

If yes, who & at what age? _____

Social

Who do you live with? _____

Are you? ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Are you employed? ☐ Yes ☐ No If yes, what is your job? _____

Are you disabled? ☐ Yes ☐ No If disabled, reason? _____

Habits

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Did you smoke in the past? ☐ Yes ☐ No If yes, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you chew tobacco? ☐ Yes ☐ No

How many cups of coffee per day? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ >4

How many cans of soda per day? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ >4

Please list your current medications and dosages:

_____

_____

_____

_____

Allergies:

_____

_____

Do you take: ☐ Goody's or ☐ BC ☐ Ibuprofen (Advil, Motrin, Nuprin, Aleve, or similar medicines) ☐ None

If yes, how many pills per week? _____

If there is anything else about your health you would like us to be aware of, please mention it below.

_____

_____

Preventative Care

Have you ever had a colonoscopy for colorectal cancer screening? ☐ Yes ☐ No

If yes, when was your last colonoscopy performed? _____

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Please answer some questions about your general health.

Date: _____

GEN Do you have a weight problem? ☐Yes ☐No
Have you lost weight recently? ☐Yes, how many lbs? _____ ☐No
Have you gained weight? ☐Yes, how many lbs? _____ ☐No
Any fever or sweating chills? ☐ Current ☐Past ☐None

EYES Do you have trouble with your vision? ☐Current ☐Past ☐None
(Other than needing glasses)
Do you have glaucoma? ☐Current ☐Past ☐None

ENT Do you have hearing trouble? ☐Current ☐Past ☐None
Recurrent nosebleeds? ☐Current ☐Past ☐None
Sinus problems? ☐Current ☐Past ☐None
Hoarseness? ☐Current ☐Past ☐None

CV Do you have chest pains or angina? ☐Current ☐Past ☐None
Shortness of breath? ☐Current ☐Past ☐None
Passing out spells? ☐Current ☐Past ☐None
Swelling of your ankles? ☐Current ☐Past ☐None

RESP Do you have a cough? ☐Current ☐Past ☐None
Asthma or wheezing? ☐Current ☐Past ☐None
Have you ever had tuberculosis? ☐Current ☐ Past ☐None

GI Do you have heartburn? ☐Current ☐Past ☐None
If yes, ☐Daily ☐Weekly ☐less than ones a week
Do you have difficulty swallowing? ☐Current ☐Past ☐None
Nausea? ☐Current ☐Past ☐None
Vomiting? ☐Current ☐ Past ☐None
Diarrhea? ☐Current ☐Past ☐None
Constipation? ☐Current ☐ Past ☐ None
Uncontrolled leakage of stool? ☐ Current ☐Past ☐None
Rectal bleeding? ☐Current ☐Past ☐ None
Black stools that look like tar? ☐Current ☐Past ☐None
Have you ever had hepatitis or jaundice? ☐ Current ☐Past ☐None

GU Do you currently have ☐painful? Or ☐frequent urination?
Blood in your urine? ☐Current ☐Past ☐ None
Have you had kidney stones? ☐ Current ☐Past ☐None
Abnormal menstrual bleeding? (women only) ☐ Current ☐Past ☐None

MS Do you have
Joint pain or arthritis? ☐ Current ☐ Past ☐None
Back pain? ☐ Current ☐Past ☐None
Prominent muscle soreness or aches? ☐Current ☐ Past ☐None

If yes, where? _____

INT Do you have a skin rash? ☐ Current ☐ Past ☐ None
Problems with repeated itching? ☐ Current ☐ Past ☐ None

NEU Frequent headaches? ☐ Current ☐ Past ☐ None
Have you had seizures? ☐ Current ☐Past ☐None
Have you ever had a stroke? ☐ Current ☐Past ☐None

HEME Have you ever had a blood transfusion? ☐Yes, year _____ ☐ No
Do you have bleeding tendencies? ☐Yes ☐ No
If yes, please explain: _____☐_____
Have you been treated for blood clots? Yes ☐ No

PSYCH Are you depressed? ☐ Current ☐ Past ☐None
If yes, would you call this depression:
☐ Mild ☐Moderate ☐Severe
Do you have problems with your nerves
or feel under excessive stress? ☐ Current ☐Past ☐None
If yes, would you call this stress/nerves: ☐Mild ☐Moderate ☐ Severe
Have you ever been a victim of sexual
or physical abuse? ☐Current ☐Past ☐None

Please explain below the symptoms you have currently: