TWIN RIVERS GASTROENTEROLOGY CENTER QUESTIONNAIRE

PATIENT NAME:_____ DOB:_____ DATE:_____

Please complete the following questionnaire. Information contained here will not be released to anyone unless you authorize this office to do so. We appreciate your time and patience in completing this questionnaire so that we can better meet your health care needs.

Reason for visit today: _____

Do you have an advanced directive, living will or durable power of attorney? YES NO If yes, please provide copy

Name of Medical Decision Maker:_____

Would you like information on how to obtain any of these for yourself? YES NO

Please circle yes or no for your answers to the questions below and indicate if you are reporting a history of or the reason for your visit today.

1	Any abdominal pain or discomfort?	YES	NO	☐	HISTORY OF	☐ REASON FOR VISIT TODAY
	Does pain occur after or during meals?	YES	NO			
	Does pain wake you up in the middle of the night?	YES	NO			
	Does eating or taking antacids relieve the pain?	YES	NO			
	Is pain worse after a large meal or greasy/fried foods?	YES	NO			
2	Do you frequently get heartburn?	YES	NO	☐	HISTORY OF	☐ REASON FOR VISIT TODAY
3	Nausea or vomiting?	YES	NO	☐	HISTORY OF	☐ REASON FOR VISIT TODAY
4	Weight loss? If so how much? _____ When?_____	YES	NO	☐	HISTORY OF	☐ REASON FOR VISIT TODAY
5	Difficulty swallowing or food getting "stuck"?	YES	NO	☐	HISTORY OF	☐ REASON FOR VISIT TODAY
6	History of peptic, duodenal or bleeding ulcers? When? _____	YES	NO			☐ REASON FOR VISIT TODAY
7	Have you had a change in bowel habits?	YES	NO	☐	HISTORY OF	☐ REASON FOR VISIT TODAY
	Diarrhea?	YES	NO			
	Constipation?	YES	NO			
	Crampy pain in abdomen?	YES	NO			
	Pain related to bowel movement?	YES	NO			
	Blood in stool, rectal bleeding or black tarry stools?	YES	NO			
	Mucus in stools?	YES	NO			
	Ribbon or tape-like stools?	YES	NO			
	Require strong laxatives?	YES	NO			
	Stools pale in color or urine dark in color?	YES	NO			
8	Ever had a blood transfusion? When?_____	YES	NO			
9	Do you take any herbs?	YES	NO			

TWIN RIVERS GASTROENTEROLOGY CENTER QUESTIONNAIRE

PATIENT NAME:_____ DOB:_____ DATE:_____

10 History of hepatitis or family history of liver problems?	YES	NO			☐	REASON FOR VISIT TODAY
11 Drink alcohol on a regular basis in the past or present? How much? _____ For how long? _____	YES	NO			☐	REASON FOR VISIT TODAY
12 Smoked cigarettes, cigars or pipes in the past? Specify _____	YES	NO			☐	REASON FOR VISIT TODAY
13 Use street drugs now or in the past?	YES	NO	☐	HISTORY OF	☐	REASON FOR VISIT TODAY
14 Take Aspirin, Alka Seltzer, Coumadin, Plavix or other blood thinners?	YES	NO	☐	HISTORY OF	☐	REASON FOR VISIT TODAY
15 Any medical illness? Specify:_____						
16 Allergies to medications, food or x-ray dye? Specify: _____						NONE
17 Please list past operations: _____						
_____						NONE
18 History of cancer? Specify: _____	YES	NO			☐	REASON FOR VISIT TODAY
19 History of polyps? At what age? _____	YES	NO			☐	REASON FOR VISIT TODAY
20 Blood relative with history of cancer, colitis, crohn's disease or colon polyps?		YES		NO	☐	REASON FOR VISIT TODAY
21 Have you or any family member had any problems with anesthesia?	YES	NO				

If you have been experiencing any of the following, please check the ones that apply to you:

☐ Headache	☐ Chest Pain	☐ Wheezing	☐ Easy bruising	☐ Weakness/ Paralysis
☐ Fever	☐ Palpitations	☐ Shortness of Breath	☐ Arthritis	☐ Dizzy/ Light headed
☐ Chills	☐ Fainting	☐ Burning on urination	☐ Rashes,skin problems	☐ Seizures or tremors
☐ Night sweats	☐ Cough	☐ Vaginal bleeding	☐ Swelling	☐ Eye problems