Today's Date:

Grand Junction Gastroenterology

Patient Information Questionnaire

Pt. Name:	**Primary Physician:**
Birthdate:	
Marital Status: _ Single _ Married _ Separated _ Divorced _ Widowed	
Occupation:	
Hospitalizations/Surgeries List illnesses or operations and approximate dates.	
Medications List all medications including birth control, over the counter medicines and any herbal remedies.	
See attached medication information sheet.	
Medication Allergies List medication and the reaction	
Allergy to Latex _ yes _ no	
Reason for Today's Visit: ***(Please include approx. month & year of onset)***	
Family Health History	
Does any member of your family have a known history of *(family member information only, not patient)*	

Illness	**Relationship** (father, mother, etc)	**Living**	**Deceased**
Gallstones			
Colon polyps			
Colon cancer			
Other Cancers			
Colitis			
Liver Disease			
Has your Primary Care Physician discussed colon cancer screening with you?		**Yes**	**No**

Personal Health History *Patient Specific*	
Use of substances:	
_ smoking *packs/day*	_ chewing tobacco
_ marijuana *number of times per day*	_ alcohol *number of drinks/day*
_ caffeinated beverages *per day*	_ other substances *usage*

Personal Health History		
Check √ only those that apply		***Patient Comments***
	Anxiety /depression	
	Artificial Joint replacements	
	Arthritis	
	Migraine headaches	
	Anemia	
	Bleeding Disorders	
	Tuberculosis	
	Asthma	
	Emphysema	
	On Oxygen *how much/often*	liters
	Heart Disease?	
	Have you had a heart valve replacement?	
	Do you have an Internal Pacemaker?	
	Thyroid Disease	
	Kidney Disease	on Dialysis _ yes _ no
	Liver Disease	
	Hepatitis	
	Jaundice	
	Gallstones/Gallbladder disease	
	Colon polyps	
	Colon cancer	
	Colon surgery	
	Other cancers	
	Stomach ulcers	
	Ulcerative Colitis or Crohn's Disease	
	Diabetic	Insulin Dependent _ yes _ no
	Wt loss	amt: lbs. over time period
	Wt gain	amt: lbs. over time period
	Have you vomited blood?	
	Have you had rectal bleeding?	
	Black stools	
	Diarrhea	
	Have you noticed any recent changes in your bowel habits/movements.	
	Do you take laxatives regularly (over the counter or herbal)	
	Constipation	
	Do you have a lot of gas/bloating?	
	Do you have a poor appetite?	
	Do you have heartburn?	
	Do you have trouble swallowing?	
	Do you have nausea or vomiting?	
	Abdominal Pain	
	Shortness of breath	
	Chronic Cough	
	Hoarseness	

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Patient Full Name: _____

Birthdate: _____

Medication Information Sheet

Please complete the following and bring it with you for your appointment.

Name:

Date completed:

Medication allergies: (please list the reaction)

Please spell the medications exactly as listed on the prescription bottle.

Drug name	Amount in milligrams	How many times a day do you take this?