McKenzie Gastroenterology Associates

New Patient Medical History Questionnaire

Name:_____ DOB:_____

PCP:_____

Chief Complaint/ Reason for visit (In your own words please describe the reason for your visit):

Review of Symptoms: Circle any item you have experience within the past 3 months:

General

Fever or Chills
Malaise
Weakness
Increase in appetite
Decrease in appetite
Night sweats
Weight increase
Weight decrease

Eyes/Ears/Nose/Throat

Eye pain
Change in vision
Hearing loss/ringing in ears
Hoarseness
Neck swelling/lumps
Soreness in mouth
Nose bleeds

Respiratory

Difficulty breathing
Wheezing
Cough
Coughing up blood

Cardiovascular

Chest pain
Leg/ankle swelling
Palpitations
Irregular heartbeat

Gastrointestinal

Abdominal pain
Change in bowel habits
Constipation
Diarrhea
Difficulty swallowing
Bloody or black stool

Urinary

Blood in urine
Difficulty urinating

Female

Pregnant
Heavy menstrual bleeding
Irregular menstrual periods

Neurologic/Mood

Dizziness
Headache
Coordination problems
Numbness
Anxiety
Depression
Increased stress
Memory loss/confusion

Skin/Joints

Rash or Hives
Itching
Hair loss
Back pain/joint pain
Muscle pain/cramps

Hematologic

Easy bleeding
Easy bruising

Immune

Food allergies
Immunosuppression
Seasonal Allergies

Family History

Please check any of the following for parents, siblings, grandparents, aunts, or uncles (indicate maternal or paternal):

☐ Ulcerative Colitis:_____
☐ Crohn's Disease:_____
☐ Colon Polyps:_____
☐ Diverticulitis:_____
☐ Liver Disease:_____
☐ Pancreas Disease:_____
☐ Gallbladder disease:_____
☐ Ulcers:_____
☐ Swallowing disorder:_____
☐ GI Bleeding:_____
☐ Celiac Disease::_____
☐ Anemia:_____
☐ Heart attack:_____
☐ Coronary artery disease:_____
☐ Congestive heart disease:_____
☐ Hypertension:_____
☐ Atrial fibrillation:_____
☐ Blood clots:_____
☐ Asthma:_____
☐ COPD:_____
☐ Cancer:_____
☐ Diabetes:_____
☐ Thyroid Disease:_____

CONTINUED ON PAGE #2

Social History (Please circle yes or no):

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

Do you use tobacco? Yes or No If yes, how many per day?_____ Quit/when_____

Do you drink caffeine? Yes or No If yes, how many drinks per day?_____

Surgical History (please check if you have had any of the following surgeries or procedures and list year performed):

- ☐ Appendix removal:_____
- ☐ Gallbladder removal:_____
- ☐ Heart surgery:_____
- ☐ Colon resection:_____
- ☐ Hysterectomy:_____
- ☐ Hernia:_____
- ☐ Kidney surgery:_____
- ☐ Stomach surgery:_____
- ☐ Gastric bypass:_____
- ☐ Lap band: _____
- ☐ Tubal ligation:_____
- ☐ Pacemaker:_____
- ☐ Splenectomy:_____
- ☐ Mastectomy:_____
- ☐ MRI:_____
- ☐ CT scan:_____
- ☐ Ultrasound:_____
- ☐ X-ray:_____
- ☐ Blood tests_____
- ☐ Other:_____

Other surgery not listed: _____

Have you ever had an upper endoscopy (EGD)? _____Yes ____No If yes, when? _____

Have you ever had a colonoscopy? ____Yes ____No If yes, when?_____

Allergies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medications (Please list all current medications, dosages, and frequency of use):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____