HEALTH QUESTIONNAIRE

Please print clearly

Indiana Gastroenterology, Inc. / www.indianagastro.com

Name:	Date:	Chart ID:
Reason for visit:		

Personal medical history (current & past)

	Yes	No		Yes	No		Yes	No
Stomach ulcers	❑	❑	GERD / Reflux	❑	❑	Colon cancer	❑	❑
Irritable bowel (IBS)	❑	❑	Crohn's disease	❑	❑	Ulcerative colitis	❑	❑
Liver disease	❑	❑	Hepatitis	❑	❑	Pancreatitis	❑	❑
Diverticulitis	❑	❑	Gall stones	❑	❑	Alcoholism	❑	❑
Heart disease	❑	❑	Irregular heart rhythm	❑	❑	Colon polyps	❑	❑
High blood pressure	❑	❑	Diabetes	❑	❑	High cholesterol	❑	❑
Asthma	❑	❑	Emphysema / COPD	❑	❑	Sleep apnea	❑	❑
Anemia	❑	❑	Thyroid disease	❑	❑	Seizures	❑	❑
Stroke	❑	❑	Anxiety	❑	❑	Depression	❑	❑
Kidney disease	❑	❑	Arthritis	❑	❑	Glaucoma	❑	❑
Cancer	❑	❑	TB or positive PPD	❑	❑	Bleeding disorder	❑	❑

Previous surgeries ❑ No abdominal surgeries

❑ Appendectomy	❑ Gallbladder	❑ Bowel resection	❑ Exploratory
❑ Hernia repair	❑ Esophageal	❑ Pancreas	❑ Liver
❑ Bariatric / weight loss	❑ Internal defibrillator	❑ Mechanical heart valve	❑ Pacemaker
❑ Hysterectomy	❑ Ovary / Ovaries	❑ Cesarean section	

List other surgeries

Previous endoscopy

❑ Upper endoscopy/EGD	❑ Colonoscopy	❑ Sigmoidoscopy	❑ ERCP

Medication list (prescription, over the counter and herbal / alternative) ❑ Refer to attached list

Pharmacy (name, address and phone number)

Medication Allergies (include reactions if known) ❑ No known drug allergies

Social / personal history (current & past)

Yes	No		Yes	No	
❑	❑	Smoking Packs per day =	❑	❑	Alcohol Drinks per day =
❑	❑	Recreational drug use	❑	❑	Tattoos
❑	❑	Received hepatitis A vaccination	❑	❑	Received hepatitis B vaccination

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed Number of children =

Occupation: ❑ Retired ❑ Disability

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Family history (indicate those medical problems identified in your relatives)						❑ Unknown / Adopted	
	Yes	No		Yes	No		Yes	No
Colon polyps	❑	❑	Colon cancer	❑	❑	Liver disease	❑	❑
Crohn's disease	❑	❑	Ulcerative colitis	❑	❑	Gall stones	❑	❑
Irritable bowel (IBS)	❑	❑	Pancreatitis	❑	❑	Iron overload / excess	❑	❑
Celiac / Sprue	❑	❑	Other cancer	❑	❑			

Do you have any of the following symptoms?								
	Yes	No		Yes	No		Yes	No
Loss of appetite	❑	❑	Abdominal pain	❑	❑	Vomiting blood	❑	❑
Weight gain	❑	❑	Excessive belching	❑	❑	Regurgitation	❑	❑
Weight loss	❑	❑	Black tarry stools	❑	❑	Blood in urine	❑	❑
Frequent itching	❑	❑	Abdominal bloating	❑	❑	Painful urination	❑	❑
Rash	❑	❑	Bloody stools	❑	❑	Frequent urination	❑	❑
Headache	❑	❑	Bowel habit changes	❑	❑	Joint pain	❑	❑
Eye pain	❑	❑	Constipation	❑	❑	Numbness	❑	❑
Neck mass	❑	❑	Diarrhea	❑	❑	Weakness	❑	❑
Cough	❑	❑	Difficulty swallowing	❑	❑	Hot / cold intolerance	❑	❑
Wheezing	❑	❑	Excessive gas	❑	❑	Anxiety	❑	❑
Chest pain	❑	❑	Heartburn	❑	❑	Depression	❑	❑
Fainting / blacking out	❑	❑	Nausea	❑	❑	Memory loss	❑	❑
Heart palpitations	❑	❑	Painful swallowing	❑	❑	Easy bruising	❑	❑
Shortness of breath	❑	❑	Vomiting	❑	❑	Prolonged bleeding	❑	❑
Female patients only								
Menopause	❑	❑	Abnormal menses	❑	❑	Date of last menses		
Oral contraceptive	❑	❑	Pregnant	❑	❑			

What testing has been performed to evaluate your current condition / problem that you were referred for?								
	Yes	No		Yes	No		Yes	No
Blood work	❑	❑	Stool tests	❑	❑	Urine tests	❑	❑
Colonoscopy	❑	❑	Upper endoscopy/EGD	❑	❑	Sigmoidoscopy	❑	❑
Capsule endoscopy	❑	❑	ERCP	❑	❑	Breath tests	❑	❑
Barium enema	❑	❑	Upper GI	❑	❑	Ultrasound	❑	❑
CT scan	❑	❑	MRI	❑	❑			

List other gastroenterologists that are or have been involved in your care		

List your surgeon and other doctors and their specialty who are currently involved in your care		
Surgeon:		

I certify that I have answered the above questions to the best of my knowledge and that all the information I have provided is correct.

Patient / responsible party signature Date Relationship if other than patient

Office use only / Chart ID: