CFAGI

Center for Advanced Gastroenterology

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PATIENT QUESTIONNAIRE

Name	**Date**
Date of Birth	**Primary Care Physician**

When was the last time you were in our office? _____

Reason for Visit today _____

Other Reason for Visit	☑ Check	How long?	Other Reason for Visit	☑ Check	How long?
Diarrhea			**Chronic Cough**		
Constipation			**Upper Abdominal Pain**		
Change in Bowel Habits			**Mid Abdominal Pain**		
Black Stool			**Lower Abdominal Pain**		
Hemorrhoids			**Elevated Liver Function Test**		
Rectal Bleeding			**Cirrhosis**		
Rectal Pain			**Hepatitis B**		
Screening Colonoscopy			**Hepatitis C**		
Bloating/Gas/Belching			**Abnormal Radiology Test**		
Heartburn/Reflux			**Gallbladder Disease**		
Atypical Chest Pain			**Pancreatitis**		
Nausea			**Weight Loss**		
Ulcerative Colitis			**Crohns Disease**		
Vomiting/Vomiting Blood			**Jaundice (yellowing of eyes or skin)**		

FAMILY HISTORY (Please Check)

	Father	**Mother**	**Brother**	**Sister**	**Grandmother**	**Grandfather**
Heart Disease						
Hypertension						
Stroke						
Cancer						
Colon Cancer/Polyps						
Diabetes						
Stomach Ulcer						
Gallbladder Disease						
Kidney Disease						

Do You (Circle)			**Do You Take (Circle)**	
Smoke	**Yes / No**		**Aspirin**	**Plavix**
Drink	**Yes / No**		**Coumadin**	**Arthritis Medication**
Use Drugs	**Yes / No**		**Advil**	**Naproxen/NSAIDS**

Date of your Last Colonoscopy	
Date of your Endoscopy	

PATIENT QUESTIONNAIRE

Name	Date

Drug Allergies

Current Medications

Hospitalization For Surgery			
Reason	**Date**	**Reason**	**Date**

Past Medical History (Please Circle)			
Rheumatic Fever	**Diabetes**	**Asthma**	**Lung Disease**
Heart Attack	**Congestive Heart Failure**	**Heart Murmur**	**Hypertension**
High Cholesterol	**Hiatal Hernia**	**GERD**	**Esophageal Stricture**
Ulcer	**Chronic Liver Disease**	**Gallbladder Disease**	**Kidney Disease**
Colon Polyps	**Cancer**	**Arthritis**	**Stroke**
Seizure	**Anxiety/Depression**	**Anemia**	**Pulmonary Embolism**
Hepatitis B/C	**Aortic Aneurysm**	**Tuberculosis**	
Other:			

Systemic Review: Please Circle if you are currently experiencing any of these symptoms		
Headache	**Vomiting**	**Muscle Pain**
Double Vision	**Diarrhea**	**Skin Rash**
Dizziness	**Constipation**	**Frequent Urinating**
Chest Pain	**Rectal Bleeding**	**Burning while Urinating**
Shortness of Breath	**Blood in Stool**	**Blood in Urine**
Chronic Cough	**Arthritis**	**Weakness**
Nausea	**Joint Pain**	
Other:		

Doctor's Notes