 **Florida Medical Clinic Gastroenterology**

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**Patient Questionnaire**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for your visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Doctor:** (no nurse practitioner)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies:** Do you have any known allergies to medications, latex, or surgical tape? Please circle **YES or NO**. If yes, please list the allergy and the reaction.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** What medications are you currently taking? Include over-the-counter, herbal, natural remedies, and ALL vitamins.

 If none, please check here: \_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Name | Strength/Dosage |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Pharmacy**:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # and Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Age | Health Issues | Age of Death | If deceased, cause |
| Father |  |  |  |  |
| Mother |  |  |  |  |
| Siblings |  |  |  |  |
|  B/S |  |  |  |  |
|  B/S |  |  |  |  |
|  B/S |  |  |  |  |
|  B/S |  |  |  |  |
|  B/S |  |  |  |  |
| Spouse |  |  |  |  |
| Children |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has anyone in your immediate family (*parents, sisters/brothers*) been diagnosed with the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Illness** | **Yes** | **No** | **Who?** |
| Allergies |  |  |  |
| Asthma |  |  |  |
| Alzheimer’s |  |  |  |
| Bleeding Disorder |  |  |  |
| Cancer: (type) |  |  |  |
| Colon Polyps |  |  |  |
| Depression |  |  |  |
| Diabetes |  |  |  |
| Emphysema |  |  |  |
| Heart Disease |  |  |  |
| Hepatitis: (type) |  |  |  |
| High Blood pressure |  |  |  |
| Liver Disease |  |  |  |
| Mental Disorder |  |  |  |
| Stroke |  |  |  |
| Tuberculosis |  |  |  |

**Social History** (please circle one)

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently smoke? **Yes/No** Do you drink caffeinated beverages? **Yes/No**

 How many per day? \_\_\_\_\_\_\_ How many per day? \_\_\_\_\_\_\_\_

 How many years total? \_\_\_\_\_\_ Alcohol use? **Yes/No**

Former smoker? **Yes/No** if so, how often? **Social / Daily**

Never a smoker? **Yes /No** Do you currently use illegal drugs? **Yes/No**

 Which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? **Yes/No** Have you had a transfusion? **Yes /No**

***Females only***: Are you pregnant, planning a pregnancy, or nursing a child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgery History:**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Surgery*** | ***When?*** | ***Surgery*** | ***When?*** |
| Appendectomy |  | Hip replacement |  |
| Bladder surgery |  | Hysterectomy: Complete or Partial |  |
| Breast biopsy |  | Knee replacement |  |
| Carpal tunnel |  | Mastectomy |  |
| C-section |  | Prostate surgery |  |
| Colon surgery |  | Tonsillectomy |  |
| Gallbladder removal |  | Tubal ligation |  |
| Gastric bypass |  | Vasectomy |  |
| Hemorrhoidectomy |  | Other: |  |
| Heart surgery |  |  |  |
| Hernia repair |  |  |  |

**Last colonoscopy**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Upper endoscopy**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been diagnosed with:**

|  |  |  |
| --- | --- | --- |
| * Defibrillator
 | * Diverticulosis
 | * HIV
 |
| * Anemia
 | * Emphysema
 | * IBS
 |
| * Anxiety
 | * Epilepsy
 | * Kidney Disease
 |
| * Arthritis
 | * Fibromyalgia
 | * Lupus
 |
| * Asthma
 | * Gallstones
 | * Migraine
 |
| * Atrial Fibrillation
 | * Glaucoma
 | * Obesity
 |
| * Broken Bones
 | * GERD
 | * Osteoarthritis
 |
| * Cancer (type)
 | * Gout
 | * Osteoporosis
 |
| * Cirrhosis of the liver
 | * Heart Attack
 | * Pneumonia
 |
| * Colitis
 | * Heart Disease
 | * Rheumatic Fever
 |
| * Congestive Heart Failure
 | * Heart Murmur
 | * STD
 |
| * COPD
 | * Hemorrhoids
 | * Stroke
 |
| * Depression
 | * Hepatitis
 | * Sleep Apnea
 |
| * Diabetes
 | * High Blood Pressure
 | * Thyroid Disorder
 |
| * Diverticulitis
 | * High Cholesterol
 | * TMJ
 |
| * Crohn’s Disease
 | * Ulcerative Colitis
 |  |

**Are you currently experiencing:**

|  |  |  |
| --- | --- | --- |
| General | Respiratory | Psychiatric |
| * Weakness
 | * Shortness of breath
 | * Anxiety
 |
| * Fatigue
 | * Loss of breath on exertion
 | * Depression
 |
| * Change in weight
 | * Persistent cough
 | * Mood swings
 |
| * Change in appetite
 | Genitourinary | * Insomnia
 |
| * Sleeping habits
 | * Change in urine habits
 | * Memory loss
 |
| * Chills
 | * Blood in urine
 | Endocrine |
| * Fever
 | * Weak or diminished stream
 | * Frequent urination
 |
| * Night sweats
 | * Urine incontinence
 | * Excessive thirst
 |
| * Intolerance to heat/cold
 | * Genital lesions
 | * Hair loss
 |
| Eyes | * Genital discharge
 | Hematological |
| * Change in vision
 | Musculoskeletal | * Unusual bleeding
 |
| * Double vision
 | * Joint pain
 | * Bruise easily
 |
| * Loss of vision
 | * Muscle pain
 | * Skin lumps
 |
| * Eye pain
 | Dermatological | Gastrointestinal |
| * Excessive tearing
 | * Rash
 |  |
| ENT | * Hair changes
 |  |
| * Sinus pain
 | * Skin lesions or masses
 |  |
| * Hoarseness
 | Neurological |  |
| * Loss of hearing
 | * Headache
 |  |
| Cardiovascular | * Dizziness
 |  |
| * Chest pain
 | * Localized weakness
 |  |
| * Chest pressure
 | * Tingling or numbness
 |  |
| * Palpitations
 | * Loss of sensation
 |  |
| * Irregular heart beat
 |  |  |

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_