 **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_