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: _____
Do you currently smoke? **Yes/No**
How many per day? _____
How many years total? _____
Former smoker? **Yes/No**
Never a smoker? **Yes /No**

Do you exercise regularly? **Yes/No**

Marital Status:_____
Do you drink caffeinated beverages? **Yes/No**
How many per day? _____
Alcohol use? **Yes/No**
if so, how often? **Social / Daily**
Do you currently use illegal drugs? **Yes/No**
Which one? _____
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**:_____

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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:_________________________