Gastroenterology Associates, P.C.
Patient History Questionnaire

Name: _____ **Date:** _____
DOB: _____

How did you hear about us? : ○*Website/Online* ○*Physician Referral* ○*Friend/Family Member* ○*Already a patient*

PERSONAL MEDICAL HISTORY:

□ Acid Reflux	□ Colon Cancer	□ Heart Attack	□ Kidney Stone
□ AICD	□ Colon polyps	□ Hemorrhoids	□ Lactose intolerance
□ AFIB	□ Congestive Heart Failure	□ Hepatitis A	□ Malignant Hyperthermia
□ Alcoholism	□ Crohn's Disease	□ Hepatitis b	□ Pancreatitis
□ Anemia	□ Depression	□ Hepatitis C	□ Peptic Ulcer
□ Anxiety	□ Diabetes	□ Hiatal Hernia	□ Rheumatoid arthritis
□ Arthritis	□ Diverticulitis	□ High Cholesterol	□ Seizures
□ Asthma	□ Diverticulosis	□ High blood pressure	□ Sleep apnea
□ Barrett's	□Emphysema	□ Hyperthyroid	□ Small bowel obstruction
□ Cardiac stent placement	□ Fatty Liver	□ Hypothyroid	□ Ulcerative Colitis
□ Celiac Disease	□ H. Pylori	□ IBS	□ Cancer: _____

Other: _____

SOCIAL HISTORY:

Tobacco Use:	Alcohol Use:	Marital Status
□ Never Smoker	□ None	□ Single
□ Former Smoker	□ Past use	□ Married
□ Current every day smoker – packs per day: ____	□ Recovering Alcoholic	□ Divorced
	□ Occasional/Social use - Amount: _____	□ Widow

Occupation: _____

SURGICAL HISTORY:

Appendix Removed	□ No	□Yes	Gallbladder Surgery	□ No	□Yes
Artificial Joints	□ No	□Yes	Ovaries Removed	□ No	□Yes
Colon Surgery	□ No	□Yes	Uterus Removed	□ No	□Yes

Other: _____

FAMILY HISTORY:

The Following Family Members Should Be Considered: Mother/Father, Brothers/Sisters, Children, Paternal Aunts/Uncles, Maternal Aunts/Uncles, Paternal Grandparents, Maternal Grandparents, Nieces/Nephews

			Relation				**Relation**
Colon Cancer	□No	□Yes	_____	Celiac Disease	□ No	□Yes	_____
Colon polyps	□ No	□Yes	_____	Crohn's Disease	□ No	□Yes	_____
Ovarian Cancer	□ No	□Yes	_____	Liver Disease/Hepatitis	□ No	□Yes	_____
Uterine Cancer	□ No	□Yes	_____	Ulcerative Colitis	□ No	□Yes	_____
Gastric Cancer	□ No	□Yes	_____	Esophageal Cancer	□ No	□Yes	_____
Pancreatic Cancer	□ No	□Yes	_____	Malignant Hyperthermia	□ No	□Yes	_____

Other: _____ _____

LYNCH SYNDROME QUESTIONS: **The Following Family Members Should Be Considered:**: Mother/Father, Brothers/Sisters, Children, Paternal Aunts/Uncles, Maternal Aunts/Uncles, Paternal Grandparents, Maternal Grandparents, Nieces/Nephews		Self	Relation	Age
□Yes □ No	Have you or any family member been diagnosed with **Colon cancer at 50 years of age or younger?**			
□Yes □ No	Have you or any family member been diagnosed with **endometrial (uterine) cancer at 50 years of age or younger?**			
□Yes □ No	**Has there been TWO or more of the following cancers diagnosed in your family?** (colon, endometrial, ovarian, stomach, small bowel, biliary tract, kidney, brain, pancreatic)			

*******PLEASE TURN PAGE OVER AND COMPLETE BACK *******

Be sure to list ALL of your current medications/allergies below			
Medication	**Strength**	**Dose**	**Reason**

Allergies:	**Severity & Reaction:**