**TRI-STATE GASTROENTEROLOGY ASSOCIATES**

Patient Name:_____
D.O.B.:_____ AGE: _____
Family Doctor:_____

# PATIENT HISTORY QUESTIONAIRE

What is the reason for your visit? _____

What first caused you to see a doctor? _____

How long has this problem existed? _____

**PLEASE CIRCLE THE APPROPRIATE ANSWER:**

Have you experienced any abdominal pain? Yes / No
Have you experienced any nausea/vomiting? Yes / No
Do you experience frequent indigestion? Yes / No
Do you experience problems with gas? Yes / No
Have you ever had any unusual weight change? Yes/ No
Has your appetite recently changed? Yes / No
Do you feel full more easily now? Yes / No
Are there any foods that you cannot tolerate? Yes / No
Do you feel food gets stuck on the way down? Yes / No
Does it ever hurt to swallow? Yes / No
Does food ever come back up when you lie down? Yes / No
Have you ever vomited blood? Yes / No
Have you ever had any changes in bowel habits? Yes/ No

Please list ALL medications that you are ALLERGIC to.

_____
_____
_____
_____
_____
_____

How often do you take Advil, Aspirin, Motrin, Naprosyn, Celebrex, etc?

_____
_____
_____
_____

**Do you have a family history or have you ever been told that you have any of the following? Please check ALL that apply.**

- ☐ Anal Fissures
- ☐ Anal Fistulae
- ☐ Anemia
- ☐ Arthritis
- ☐ Blood clots
- ☐ Blood Transfusion
- ☐ Circulatory Problems
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Colon Polyps
- ☐ Bleeding Problems
- ☐ Colon Polyps
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis/ itis
- ☐ Esophageal Stricture
- ☐ Free Bleeding
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hemorrhoids
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Gallstones
- ☐ Kidney Stones
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Hepatitis
- ☐ Hiatus Hernia
- ☐ Hypertension
- ☐ Jaundice
- ☐ Lung Disorders
- ☐ Pancreatitis
- ☐ Stroke
- ☐ Thyroid/Goiter
- ☐ Venereal Disease
- ☐ Ulcers
- ☐ Thyroid/ Goiter
- ☐ Ulcer