Knoxville Gastrointestinal Specialists

Health Information Questionnaire

Name	Birthdate	Today's Date

Referring Physician	Reason for visit

Pharmacy Name, Address, Phone #

Circle Yes or No if you <u>currently</u> have any of the following:		
Heartburn	Yes	No
Difficulty swallowing	Yes	No
Nausea or Vomiting	Yes	No
Abdominal pain	Yes	No
Ulcer history	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Laxative use	Yes	No
Change in stool	Yes	No
Black stool	Yes	No
Blood in stool	Yes	No
Rectal bleeding	Yes	No
Hemorrhoids	Yes	No
Jaundice	Yes	No
Gallbladder surgery	Yes	No
Hepatitis	Yes	No
Prior colon polyps	Yes	No
Aspirin use	Yes	No
Arthritis medication	Yes	No
Blood thinner	Yes	No
Latex allergy	Yes	No

Circle Yes or No if you have any of the following medical problems:		
Asthma	Yes	No
Bleeding problems	Yes	No
Cancer	Yes	No
Depression/Anxiety	Yes	No
COPD/Emphysema	Yes	No
Home oxygen use	Yes	No
Diabetes	Yes	No
Heart problems	Yes	No
High blood pressure	Yes	No
HIV/AIDS	Yes	No
Kidney problems	Yes	No
Reflux disease	Yes	No
Sleep apnea	Yes	No
Stroke	Yes	No
Prior surgery	Yes	No
Prior endoscopy	Yes	No
Prior colonoscopy	Yes	No
Hepatitis A or B Vaccine	Yes	No
Date of vaccine(s): _____		
Flu vaccine	Yes	No
Date of flu vaccine: _____		

List all drug allergies:

List all other medical problems and surgery:

Please continue on reverse side →

List all current medications, prescription and over the counter, or attach medication list:

Have any members of your immediate family (parents, siblings, grandparents, children) ever had:
□ Colitis If so, whom?
□ Colon cancer If so, whom?
□ Cancer If so, whom? Location of cancer:
□ Colon polyps If so, whom?
□ Crohn's disease If so, whom?
□ Celiac disease If so, whom?
□ Heart disease If so, whom?
□ Liver disease If so, whom?
□ Pancreas disease If so, whom?
□ Other:

Circle Yes or No for the following habits and social history:		
Drink coffee	Yes	No
Smoke tobacco	Yes	No
Formerly smoked	Yes	No
Chew tobacco	Yes	No
History of IV drug use	Yes	No
Drink alcohol now	Yes	No
Number of alcoholic drinks each week: _____		
Your occupation: _____		
Who lives with you: _____		

Circle Yes or No for the following symptoms:		
Poor appetite	Yes	No
Fevers	Yes	No
Weight loss	Yes	No
Fatigue	Yes	No
Glaucoma	Yes	No
Hearing problems	Yes	No
Dentures	Yes	No
Sleep apnea	Yes	No
Shortness of breath	Yes	No
Cough	Yes	No
Coughing blood	Yes	No
Chest pain	Yes	No
Palpitation	Yes	No
Blood in urine	Yes	No
Painful urination	Yes	No
Urinary leakage	Yes	No
Bowel control issues	Yes	No
Joint pain	Yes	No
Anesthesia trouble	Yes	No
Easy bruising	Yes	No
Abnormal lumps	Yes	No
Insomnia	Yes	No
Depression	Yes	No

Please list any other relevant information:

Information provided by patient on these forms (page 1 and 2) were reviewed.

Physicians Initials: _____