Cascade Gastroenterology

Health Questionnaire

Name: DOB: Reason for visit:

Are you Currently experiencing any of the following? *Please check ALL that apply*

Abdominal Pain

- ☐ Upper/Epigastric

Location

- ☐ Upper/Epigastric
- ☐ Lower/Pelvic
- ☐ Evenly throughout Abd.
- ☐ Multiple locations

Description

- ☐ Steady, severe
- ☐ Cramping/bloating
- ☐ Burning
- ☐ Sharp/Stabbing
- ☐ Pressure/fullness

Association

- ☐ Within 30min after meals
- ☐ Diet related
- ☐ Relieved with antacids
- ☐ Relieved with bowel movements or flatus
- ☐ Awakening or you from sleep

Anemia

- ☐ Palpitations
- ☐ Low Blood
- ☐ Easy bleeding

Acid Reflux

- ☐ How often? ____/day _____/wk
- ☐ Relieved by antacids or medication
- ☐ Related to certain foods |
- ☐ Related to body position
- ☐ Feeling full before finishing meals
- ☐ Frequent throat clearing

Constipation

- ☐ Associate with medication
- ☐ Using laxative/stool softner/enema

Diarrhea

- ☐ Fecal Leakage or Incontinence
- ☐ Painful
- ☐ After traveling
- ☐ At night (waking you)
- ☐ After dairy products
- ☐ Stools per 24 hours: (circle one) 1-4 5-10 >10

Dysphagia (Difficulty Swallowing)

- ☐ Food sticking (catching going down)
- ☐ Precipitates coughing, esp. liquids
- ☐ Solids more than liquids
- ☐ Pain with swallowing
- ☐ Regurgitation
- ☐ Frequent sore throats
- ☐ Repeated cough
- ☐ Difficulty breathing

Elevated Liver Enzymes

- ☐ Prior liver biopsy

General

- ☐ Fatigue
- ☐ Tired or weak
- ☐ Dizzy/Fainting
- ☐ More than 5 lb weight change

Hepatitis

- ☐ A
- ☐ B
- ☐ C
- ☐ Abdominal swelling
- ☐ Confused or not thinking clearly,

IBS

- ☐ Prior Diagnosis Age: _________
- ☐ Primarily diarrhea
- ☐ Primarily constipation
- ☐ Unable to pass gas
- ☐ Excessive gas
- ☐ Abdominal swelling
- ☐ Bowel urgency

Jaundice

- ☐ Yellow eyes or skin
- ☐ Worsens with fasting
- ☐ After a blood transfusion
- ☐ Yellow eyes or skin
- ☐ Worsens with fasting
- ☐ After a blood transfusion

Musculoskeletal

- ☐ Joint swelling or discomfort

Nausea-Vomiting

- ☐ Yellow-green
- ☐ Clear
- ☐ Blood, coffee grounds
- ☐ Violent and prolonged
- ☐ Self-induced
- ☐ Frequency: _____________
- ☐ Recognizable food

Rectal Bleeding

- ☐ Black or tarry stools
- ☐ Bright red blood
- ☐ Positive test for blood in stool
- ☐ Stool color change to white
- ☐ Change in the stool character
- ☐ Bloody mucus

Have you been diagnosed with the following? If answer is yes, mark box with a check

- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Any Implantable Cardiac device
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Beeding Disorder
- ☐ Colon Polyps
- ☐ Colon/Rectal Cancer
- ☐ COPD/Emphysema
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Frequent Bladder Infection
- ☐ Heart Disease/Heart Attack
- ☐ Heart Failure
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Tuberculosis
- ☐ History of Blood Clots
- ☐ HIV Exposure/Infection
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Stroke
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Cancer of GI Tract
- ☐ Thyroid Disorders
- ☐ Ulcerative Colitis
- ☐ Valve Replacement
- ☐ Cancer of any type

Allergies: ____

Immunizations: (circle if received) **Hep A** **Hep B** **Flu** **Chicken Pox/Shingles** **Tetanus** **Pneumo Vax** **HPV**

Medications, prescribed and over the counter (including supplements): (EXAMPLE: Protonix 40 mg once daily)

____

____

Have you had any of the following tests? Please select a time frame for each test below. Bring records if possible.

	Never	**1-5 yrs ago**	**6-10 yrs ago**	**10+ yrs ago**
Flex Sigmoidoscopy	☐	☐	☐	☐
Colonoscopy	☐	☐	☐	☐
Upper Endoscopy	☐	☐	☐	☐
Upper GI X-Ray Series	☐	☐	☐	☐
MRI abdominal/pelvis	☐	☐	☐	☐
CT abdominal/pelvis	☐	☐	☐	☐

Surgical History: Please list the year of your surgery below, OR mark none if no history. None ☐

Appendectomy	____________	Hysterectomy	____________
Colon Resection	____________	Heart Valve	____________
Gallbladder	____________	Hernia Repair	____________
Joint Replacement	____________	Obesity Surgery	____________
Heart Bypass		Other Surgeries:	

Have you or any of your blood relatives had any of the following? If yes, please list their relation to you, OR is family history unknown due to:

☐ Adoption ☐ Estranged from Family ☐ No knowledge of my family history

	Yes	**No**		
Hemophilia; Van Willi or Sickle Cell	☐	☐	____________	____________
Breast Cancer	☐	☐	____________	____________
Cancer	☐	☐	____________	____________
Celiac Disease	☐	☐	____________	____________
Colon Polyps	☐	☐	____________	____________
Colon /Rectal Cancer	☐	☐	____________	____________
Crohn's Disease	☐	☐	____________	____________
Liver Disease	☐	☐	____________	____________
Ovarian/Uterine Cancer	☐	☐	____________	____________
Pancreatic Cancer	☐	☐	____________	____________
Pancreatitis	☐	☐	____________	____________
Esophageal Cancer	☐	☐	____________	____________
Ulcerative Colitis	☐	☐	____________	____________
Prostate Cancer	☐	☐		

Tobacco ☐ Never used tobacco
Current use:_________ packs per day
Prior use: Quit ________ months/years ago?
Other forms: ___________________________________

Alcohol ☐ Never used alcohol
Currrent use:__________ drinks/day __________ drinks/week
Prior use: Quit________ months/years ago? _______ drinks/week

Recreational/Illegal Drugs ☐ Never used recreational/illegal drugs
Currently using ________________ how often?______________________________ Last used: ________________
Previouly used:__________________ When:____________________________