

Medical Record Number

Patient Name



**CLINICS DIGESTIVE HEALTH NEW PATIENT  
QUESTIONNAIRE**

Addressograph or Label - Patient Name, Medical Record Number

Date: \_\_\_\_\_

<p><i>Referring MD (Name, Address, Phone Number):</i></p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><i>Primary Care Physician (Name and Address, Phone Number):</i></p> <p>_____</p> <p>_____</p> <p>_____</p>
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Reason for visit: \_\_\_\_\_

1. How long have you had symptoms? \_\_\_\_\_

Describe your symptoms? \_\_\_\_\_

2. Have your symptoms affected your ability to carry out your daily activities?  YES  NO

3. What diagnosis (if any) have you been given? \_\_\_\_\_

If you have changes in your bowel patterns, please fill out the section below. If you have had no changes, please skip to #4.

**BOWEL HABITS:**

**Have you recently had:**

Changes in gas  YES  NO

Blood in your stools  YES  NO

Blood after bowel movements (in toilet/ on paper)  YES  NO

Black tarry stools  YES  NO

Sticky bowel movements  YES  NO

Urgency  YES  NO

Pain **JUST BEFORE, DURING, or AFTER** bowel movements  BEFORE  DURING  AFTER

Nocturnal BMs (do BMs wake you out of your sleep)  YES  NO

# of bowel movements per day: \_\_\_\_\_

Consistency of bowel movements:  Watery  Soft  Normal  Hard Pellets



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4. Other Medical Problems (past and present):

PAST	PRESENT

5. Prior Surgeries and Hospitalizations (include month, year, location):


6. Current Medications: (include non-prescription and supplements):

PAST		PRESENT	
Medication & Dosage	Frequency	Medication & Dosage	Frequency

7. Prior Treatment for Current Problem:

PAST	PRESENT



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8. Medication allergies: \_\_\_\_\_

9. Cigarette smoking?  YES  NO

If yes, how much and how long: \_\_\_\_\_

10. How much alcohol do you drink? \_\_\_\_\_

Other drugs \_\_\_\_\_

Marijuana?  YES  NO

11. Family History (Please check and indicate family member, if appropriate)

FAMILY HISTORY	FAMILY MEMBER
<input type="checkbox"/> Crohn's Disease or Ulcerative Colitis	
<input type="checkbox"/> Celiac Sprue	
<input type="checkbox"/> Autoimmune Disorder? Lupus, Scleroderma, Arthritis	
<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Colon Cancer/ Polyps	
<input type="checkbox"/> Other Cancers	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Obesity	
<input type="checkbox"/> Depression/ Anxiety/ Substance Abuse	
<input type="checkbox"/> Other:	
<input type="checkbox"/> None of the above	

12. Do you feel depressed or anxious?  YES  NO

13. Have you ever experienced violence or abuse in your life?  YES  NO



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14. Please check Yes or No if you have had any of the following symptoms in the **past 3 months**

System	Symptoms	Yes	No	Comments
General	Fevers/Chills/Sweats	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Insomnia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Appetite Change	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Weight Loss (past year)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Minimum weight # _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Dermatologic	Rashes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Nail Changes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Head and Neck	Dry eyes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Ringing in the ears	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Sore throat	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Hoarseness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Mouth Sores	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Cardiac	Chest Pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Palpitations		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Respiratory	Difficulty breathing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Coughing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Wheezing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Genital/Urinary	Burning with urination	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Blood in urine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Urinary incontinence	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Genital sores	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Gastrointestinal	Blood in stools	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Fecal incontinence	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Difficulty swallowing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Heartburn	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Nausea	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Vomiting	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Constipation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Abdominal pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Musculoskeletal	Chronic back pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Swelling in hands or feet	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Neurologic	Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Blurred vision	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Numbness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Hematology	Bruising	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Prolonged bleeding	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
	Anemia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

