FLINT GASTROENTEROLOGY ASSOCIATES, PC

Patient Questionnaire

Today's Date_____

Last Name_____**First Name**_____**Date of Birth**_____

Gastrointestinal History

What is your chief problem or concern?_____

How long have you had this problem?_____

How was this diagnosed?_____

How did the doctor treat this problem?_____

Have you ever had a Colonoscopy?_____When?_____Performing Doctor_____

Have you ever had an EGD/Upper Scope?_____When?_____Performing Doctor_____

Have you had any recent radiology exams such as Ultrasound, CT, MRI, or X-Ray?_____When?_____Where?_____

☑Past Medical History (please check the conditions that apply to you)

☐	AIDs/ HIV	☐	Colon Polyps	☐	Heart Attack	☐	Migraine
☐	Anemia	☐	Congestive Heart Failure	☐	Heart Disease	☐	Osteoporosis
☐	Anticoagulation Therapy	☐	Coronary Artery Disease	☐	Hepatitis B or C	☐	Pancreatitis
☐	Anxiety	☐	Crohn's Disease	☐	Hyperlipidemia (high cholesterol)	☐	Seizures
☐	Arthritis	☐	Depression	☐	Hypertension (high blood pressure)	☐	Sleep Apnea
☐	Asthma	☐	Diabetes Mellitus	☐	Hypoglycemia (low blood sugar)	☐	Stroke
☐	Blood Clots	☐	Emphysema	☐	Inflammatory Bowel Disease	☐	Thyroid Disease
☐	Cancer (type)	☐	Fatty Liver	☐	Irritable Bowel Syndrome	☐	Ulcerative Colitis
☐	Chest Pain	☐	GERD	☐	Kidney Disease	☐	Other (specify)
☐	Cirrhosis	☐	Hearing Problems	☐	Liver Disease	☐	

☑Past Surgical History (check any surgeries you have had; and the date of the surgery if you know it)

☐	Appendectomy	☐	Cosmetic Surgery	☐	Hernia Repair	☐	Sterilization
☐	Bariatric Surgery	☐	C-Section	☐	Hysterectomy	☐	Tonsillectomy
☐	Bowel Resection	☐	Eye Surgery	☐	Kidney Transplant	☐	Vascular Surgery
☐	Breast Surgery	☐	Heart Surgery	☐	Liver Transplant	☐	Other (specify)
☐	Cholecystectomy	☐	Hepatobiliary Surgery	☐	Orthopedic Surgery	☐	

☑Family History (please indicate if family member is living or deceased and if they have had the following)

	Living Age	Aged Deceased	Please place family Illnesses specifically under which family member that belongs to. Examples of Illness (Colon cancer, colon polyps, stomach cancer), other cancers or diseases.
Father			
Mother			
Brother			
Sister			
Grandfather			
Grandmother			

☑Social History (please be specific and check all that apply)

Have you ever smoked?	Y	N	If yes, how many packs per day?____	Week?____	Month?____	Marijuana?_____
Do you use any street drugs?	Y	N	Please specify_____			
Do you drink alcohol?	Y	N	If yes, how often and how much? Socially? Daily? Monthly? Yearly?			
Drink of Choice?	☐	Wine	☐ Beer	☐ Hard Liquor	☐	Other (specify)
Are you on any special diets?	Y	N	Please specify_____			
Are you on any food restrictions?	☐		☐	☐	☐	

☑Allergies and Sensitivities (please check all that apply and add any others)

☐	No Known Drug Allergies	☐	Latex	☐	Iodine	☐	Aspirin
☐	No Allergies	☐	Penicillin	☐	Sulfa Drugs	☐	Contrast Dyes

Other (specify)_____

_____

☑Vaccinations (please check any immunizations you have had)

☐	Tetanus	☐	Influenza	☐	Pneumonia	☐	Hepatitis A Vaccine	☐	Hepatitis B Vaccine	☐	TB Skin Test