Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

RETURNING PATIENT QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: ____/____/____

REASON FOR VISIT: _____ TODAY'S DATE: ____/____/____

REVIEW OF SYSTEMS:

Do you CURRENTLY have any of the following? If the answer is yes, please mark the box

General:
□ Weight Loss
□ Fatigue

Heart:
□ Chest Pain
□ Shortness of Breath

Lungs:
□ Chronic Cough
□ Coughing up Blood

Kidneys:
□ Blood in Urine
□ Painful Urination

Neurologic:
□ Memory Loss
□ Fainting

Mental Health:
□ Depression
□ Hearing Voices

Ears, Nose and Throat:
□ Hearing Loss
□ Hoarseness

Blood Systems:
□ Anemia
□ Easy Bleeding

Immune System:
□ Asthma
□ Latex Allergy

GI:
□ Abdominal Pain
□ Abdominal Bloating
□ Constipation
□ Heartburn
□ Milk Intolerance
□ Passing Blood with Stool
□ Nausea
□ Swallowing Difficulty
□ Vomiting

For women only: Could you be pregnant? _____

UPDATED MEDICAL CONDITIONS:

Have you had any new serious medical conditions diagnosed or undergone any surgeries since your last visit? □ Yes □ No

Describe: _____

MEDICATIONS:

Please review the list, provided to you at check-in, for accuracy. If you are taking any new medications (prescription, over-the-counter, and supplements), please list them below. Complete the column for dosage and check the box for how often you are taking each medication. Attach additional pages if needed.

Medication Name:	Dosage:	How often are you taking?
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed
		□ 1x/day □ 2x/day □ 3x/day □ as needed

Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

Patient name: _____

Date of Birth: _____

ALLERGIES:

If you have any new allergies, please list them below:

□ None	□ Latex
□ Antibiotics *(please specify below)*	□ Egg
□ X-ray/ Radiology Contrast	□ Other *(please specify below)*

_____

_____

Smoking/ Tobacco/Nicotine Use:

Have you ever smoked or used tobacco/ nicotine products? □ Yes □ No

Used for how many years: _____ When did you quit?: _____

Cigarettes: □ Currently use □ Formerly used Cigarettes per day: _____

Cigars: □ Currently use □ Formerly used Pipe: □ Currently use □ Formerly used

Nicotine Patch: □ Currently use □ Formerly used Vape: □ Currently use □ Formerly used

Chew Tobacco: □ Currently use □ Formerly used

Alcohol Use:

Do you drink alcohol now? □ Yes □ No Have you drank alcohol in the past? □ Yes □ No

How much per week: □ beer _____ □ wine _____ □ liquor _____

Caffeine Use:

Do you drink caffeine-containing products? □ Yes □ No

How much per day: □ coffee _____ □ tea _____ □ soda _____ □ other _____

Recreational Drug Use:

Have you ever used recreational or IV drugs? □ Yes □ No Marijuana? □ Yes □ No

Ongoing Use: □ Yes □ No

Form of use: □ Smoking □ Snorting □ IV □ Oral ingestion

FAMILY HISTORY

Have your blood relatives had any of the following? *If yes, please mark the box for their relation to you.*

Colon Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent
Colon Polyps	□ Mother	□ Father	□ Sibling	□ Grandparent
Esophageal Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent
Crohn's Disease	□ Mother	□ Father	□ Sibling	□ Grandparent
Liver Disease	□ Mother	□ Father	□ Sibling	□ Grandparent
Pancreatic Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent
Stomach Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent
Ulcerative Colitis	□ Mother	□ Father	□ Sibling	□ Grandparent
Gallbladder Problems	□ Mother	□ Father	□ Sibling	□ Grandparent
Breast Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent
Ovarian Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent
Uterine Cancer	□ Mother	□ Father	□ Sibling	□ Grandparent

Signature: _____ Date: _____