Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

NEW 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

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

PAST MEDICAL HISTORY:

Have you EVER experienced any of the following? *If the answer is yes, please mark the box*

□ Anemia	□ Frequent Bladder Infection	□ Irritable Bowel Syndrome
□ Anxiety Disorder	□ Heart Attack	□ Kidney Disease
□ Artificial Joints	□ Heart Failure	□ Liver Disease
□ Asthma	□ Heart Murmur	□ Pacemaker
□ Bleeding Disorder	□ Heart Valve Replacement	□ Pancreatitis
□ Colon Polyps	□ Hepatitis	□ Rheumatic Fever
□ Colon/ Rectal Cancer	□ Hiatal Hernia	□ Seizure Disorder
□ COPD/Emphysema	□ High Blood Pressure	□ Sleep Disorder
□ Using Home Oxygen	□ High Cholesterol	□ Stomach Cancer
□ Crohn's Disease	□ History of Tuberculosis	□ Stroke
□ Depression	□ History of Blood Clots	□ Tattoos
□ Diabetes	□ HIV Infection	□ Thyroid Disorders
□ Diverticulosis	□ Implantable Defibrillator	□ Ulcerative Colitis
□ Diverticulitis	□ Implanted Stimulator	

PAST SURGICAL HISTORY:

Have you had any of the following surgeries? *If the answer is yes, please mark the box*

□ Appendix Removal	□ Heart Surgery	□ Portion of Bowel Removed
□ Gallbladder Removal	□ Hysterectomy	□ Stomach Surgery

Please list any additional surgeries: _____

_____

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Patient name: ______________________

Date of Birth: ______________________

PAST ENDOSCOPIC HISTORY:
Have you had any of the following endoscopies? *If the answer is yes, please mark the box, and complete the additional spaces.*

Type of endoscopy:	When:	Did they find Polyps:
□ Colonoscopy/ Lower scope		□ Yes □ No
□ EGD/ Upper scope		

Have you had a problem with sedation or anesthesia? (describe) ______________________

HISTORY OF VACCINATIONS:
Please mark the box if you have had the following vaccinations:

□ Hepatitis A	□ Pneumovax (pneumonia)
□ Hepatitis B	□ Flu Shot (for this season)

For women only: Could you be pregnant? ______________________

MEDICATIONS:
Please list the medications you are taking (prescription, over-the-counter, and supplements). Complete the column for dosage and mark 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
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		□ 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

ALLERGIES:
If you have experienced allergies to any of the following, please mark the box

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

____
____
____

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Patient name: _____

Date of Birth: _____

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Partnered □ Divorced □ Widowed

Children: □ Yes □ No How many? _____

Employment: □ Employed □ Not currently employed □ Disabled □ Retired □ Other

Occupation: _____

Habits:

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: _____