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

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

Describe: _____

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)*

_____

_____

MEDICATIONS:
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

Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

FAMILY HISTORY

Have your blood relatives had any of the following? *If yes, please mark the box.*

Relationship	No known problems	Colon Cancer	Crohn's disease	Esophageal cancer	Liver cancer	Ulcerative colitis	Bladder cancer	Laryngeal cancer
Mother	□	□	□	□	□	□	□	□
Father	□	□	□	□	□	□	□	□
Sister	□	□	□	□	□	□	□	□
Brother	□	□	□	□	□	□	□	□
Maternal Aunt	□	□	□	□	□	□	□	□
Maternal Uncle	□	□	□	□	□	□	□	□
Paternal Aunt	□	□	□	□	□	□	□	□
Paternal Uncle	□	□	□	□	□	□	□	□
Maternal Grandmother	□	□	□	□	□	□	□	□
Maternal Grandfather	□	□	□	□	□	□	□	□
Paternal Grandmother	□	□	□	□	□	□	□	□
Paternal Grandfather	□	□	□	□	□	□	□	□
Other	□	□	□	□	□	□	□	□

Sexual activity:

Are you sexually active: □ Yes □ Not Currently □ Never

For women only: Could you be pregnant? _____

Habits:

Alcohol Use:

Do you drink alcohol? □ Yes □ Not Currently □ Never

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

Recreational Drug Use:

Have you ever used recreational or IV drugs? ? □ Yes □ Not Currently □ Never

Marijuana? □ Yes □ No

Ongoing Use: □ Yes □ No

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

Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

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: □ Current use □ Former use Cigarettes per day: _____
Cigars: □ Current use □ Former use Pipe: □ Current use □ Former used
Nicotine Patch: □ Current use □ Former use
Chew Tobacco: □ Current use □ Former use

Vaping/ E-Liquid use:

Have you ever used vaping or e-liquid products? □ Yes □ No
Used for how many years: _____ When did you quit?: _____Cartridges per day: _____
Nicotine: □ Current use □ Former use Synthetic Cannabinoids: □ Current use □ Former use
Nicotine-Salt: □ Current use □ Former use Mix of Cannabinoids: □ Current use □ Former use
THC: □ Current use □ Former use Flavored: □ Current use □ Former use
CBD: □ Current use □ Former use

Signature: _____ Date: _____