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

GI:
□ 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	□ Diarrhea	□ Kidney disease
□ Celiac disease	□ Diverticulitis	□ Liver cancer
□ Chronic constipation	□ Esophageal cancer	□ Pancreatic cancer
□ Chronic lung disease	□ Heart murmur	□ Pancreatitis
□ Chronic pain	□ Heart burn/ GERD/ Ulcers	□ Rectal cancer
□ Cirrhosis	□ Hemochromatosis	□ Sleep apnea
□ Colon cancer	□ Hepatitis	□ Stomach cancer
□ Colon polyps	□ Inflammatory bowel disease	□ Stroke
□ Crohn's disease	□ Irregular heart rhythm	□ Ulcerative colitis
□ Diabetes	□ Irritable bowel syndrome	

PAST SURGICAL HISTORY:

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

□ Abdomen surgery	□ Colorectal resection	□ Joint replacement
□ Appendectomy	□ Colostomy	□ Liver surgery
□ Cardiac bypass surgery	□ Esophagus surgery	□ Pacemaker insertion
□ Cholecystectomy	□ Gastric fundoplication	□ Small intestine surgery
□ Colon surgery	□ Hysterectomy	□ Stomach surgery
□ Colonoscopy		

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)
□ COVID-19- compete series	

For women only: Could you be pregnant? _____

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	□	□	□	□	□	□	□	□

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: ______________________________

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

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

Children: □ Yes □ No How many? ________________

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

Occupation: ____

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

ALCOHOL USE:
Do you drink alcohol? □ Yes □ Not Currently □ Never
How many drinks do you have per week?:
□ Glasses of wine_______
□ Cans of beer _________
□ Shots of liquor ___________

RECREATIONAL DRUG USE:
Have you ever used recreational or IV drugs? ? □ Yes □ Not Currently □ Never
Which types: □ Marijuana □ Methamphetamines □ Cocaine □ Heroin
Form of use: □ Smoking □ Snorting □ IV □ Oral ingestion

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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 □ Not Currently □ Never
If you use these products, do you use: □ Every day □ Some days
Used for how many years: _____ When did you quit?: _____Cartridges per day: _____
Which substances do you or have you used?
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
What types of devices do you or have you used?
Disposable □ Current use □ Former use Pre-filled cartridges □ Current use □ Former use
Refillable tank □ Current use □ Former use Pre-filled pod □ Current use □ Former use

Signature: _____ Date: _____