New Patient Questionnaire

Name: _____ **DOB:**_____ **Date:**_____

QUESTION 1 **Please fill in circles completely like this ●, not ⊗**

O Yes	O No	Have you had continuous or repeated discomfort or pain in your lower abdomen over the past three (3) months? **(If no, please skip to #2)**
O Yes	O No	Is this discomfort or pain relieved by a bowel movement?
O Yes	O No	Is this discomfort or pain associated with a change in the frequency of bowel movement (i.e., having more or fewer bowel movements)?
O Yes	O No	Is this discomfort or pain associated with a change in the consistency of the stool (i.e., softer or harder)?

QUESTION 2 Would you say that at least one fourth (1/4) of the occasions or days in the last (3) months you have experienced any of the following:

O Yes	O No	Fewer than three (3) bowel movements per WEEK (0-2)?
O Yes	O No	More than three (3) bowel movements per DAY (4 or more)?
O Yes	O No	Hard or lumpy stools
O Yes	O No	Loose or watery stools?
O Yes	O No	Straining during a bowel movement?
O Yes	O No	Urgency – having to rush to the bathroom for a bowel movement?
O Yes	O No	Feeling of incomplete bowel movement?
O Yes	O No	Passing mucus (white material) during a bowel movement?
O Yes	O No	Abdominal fullness, bloating or swelling?

PAST MEDICAL HISTORY **Please fill in circles completely like this ●, not ⊗**

O	anxiety disorder	O	anemia	O	arthritis
O	Blood clots	O	cancer_____	O	depression
O	diabetes	O	headaches	O	heart disease
O	hepatitis	O	high cholesterol	O	HIV
O	hypertension	O	kidney/urinary problems	O	Neck/back problems
O	neurological disorders	O	osteoporosis	O	seizures
O	skin disease	O	stomach/digestive disorders	O	thyroid disease

New Patient Questionnaire

Name: _____ **DOB:**_____ **Date:**_____

SURGICAL HISTORY Please fill in circles completely like this ●, not ⊗

O	appendectomy	O	bladder suspension	O	heart bypass surgery
O	hysterectomy	O	gallbladder	O	mastectomy
O	prostate	O	tonsillectomy	O	tubal ligation
O	tumor removal	O	vasectomy	Other: _____	

REVIEW OF SYSTEMS Please fill in circles completely like this ●, not ⊗

Recent illness	O Yes	O No	Cough with sputum - yellow or clear	O Yes	O No
Recent infection	O Yes	O No	Burning with urination	O Yes	O No
Recent exposure to either	O Yes	O No	Diffuse joint pain/new onset	O Yes	O No
Recent weight change	O Yes	O No	Difficulty walking	O Yes	O No
Fever over 100 degrees in last 2 weeks	O Yes	O No	Swelling in neck	O Yes	O No
Sensory disturbances	O Yes	O No	Swelling in groin	O Yes	O No
Visual loss in 6 months	O Yes	O No	Skin rash	O Yes	O No
Double vision	O Yes	O No	Excessive itching	O Yes	O No
Dizziness	O Yes	O No	Insomnia	O Yes	O No
Ear pain or drainage	O Yes	O No	Anxiety	O Yes	O No
Unusual throat pain/soreness	O Yes	O No	Depression	O Yes	O No
Heart palpitations	O Yes	O No	Difficulty urinating	O Yes	O No
Chest pain on exertion	O Yes	O No	History of antibiotic resistant infection	O Yes	O No
Shortness of breath at rest	O Yes	O No			

New Patient Questionnaire

Name: _____ **DOB:**_____ **Date:**_____

FAMILY HISTORY: Please indicate if family member is living (Y or N) and ✓ if family has/had any of the following:

Family Member	**Living?**	**Colon cancer**	**Cancer, other**	**Diabetes**	**Heart disease**	**High blood pressure**	**Stroke**
Father							
Mother							
Brother(s)							
Sister(s)							
Other: list family member							

PROCEDURES

O Yes O No Colonoscopy If yes, date performed:_____

O Yes O No EGD (*scope used to look inside the upper digestive tract*) If yes, date performed:_____

HOSPITALIZATION O Yes O No If yes, list reason:_____

_____

SOCIAL HISTORY

Marital Status: Single __ Married __ Divorced __ Widowed __ Number of children:_____

Occupation:_____ Last grade completed:_____

HABIT HISTORY

Smoking ____ Current ____ Former ____Never Number of years smoked/quit_____

__ Cigarettes __Cigars __ Pipes __ Chewing Tobacco Number per day/week/time:

Do you drink Alcohol O Yes O No If yes, drinks per day/week:_____

Tea/Coffee (hot/cold):____/day Sodas: ____oz/day

New Patient Questionnaire

List ***ALL*** medications taken within the last ***30 days***. Please print clearly.

Patient Name: _____ DOB: _____

Drug Allergies: _____

Medication	Dose	Times a Day	Start Date	Stop Date	Reason Taking

***Attach any additional medications on separate paper if necessary.

Please mark any of the following over the counter or non-prescription medications:

- ☐ Aspirin:_____
- ☐ Advil, Motrin, etc.: _____
- ☐ Allergy Medications: _____
- ☐ Antacids: _____
- ☐ Vitamins: _____
- ☐ Laxatives:_____
- ☐ Weight Loss Products: _____