Regional Digestive Consultants, PA

New Patient Health Questionnaire

Dear Patient: Thank you for taking the time to complete this form prior to your appointment. Please complete all pages of this form in a timely manner, as it will help ensure an efficient visit with our physician. You can access this form on our **secure patient portal** after registering with our office or may download this form from our website www.regionaldigestiveconsultants.com

Today's date: ____/____/________

Name___________________________________ Date of Birth ____/____/________ Age:______

Your Primary Care Physician: _________________ Physician who referred you to us_____________________

Symptoms or Reason for Visit_______________________

Have you had any tests done (blood work, x-rays etc.,) pertaining to the reason for this visit?☐Yes ☐ No

Female Patients: Date of your last pelvic examination ___/___/________

Do you have a living will? ☐ Yes ☐ No Do you have a healthcare power of attorney? ☐ Yes ☐ No

Medical History – Past or Present Medical conditions (If answer is **Yes,** please check the box)

☐ None

○	Anemia	○	Celiac Sprue	○	History of Tuberculosis
○	Anxiety Disorder	○	Depression	○	History of Blood Clots
○	Alcoholism	○	Diabetes or pre-diabetes	○	HIV AIDS
○	Any implantable Stimulator	○	Diverticulosis	○	Implantable Defibrillator
○	Artificial Joints	○	Diverticulitis	○	Irritable bowel syndrome
○	Asthma	○	Drug Dependency	○	Kidney Disease
○	Auto immune/ Rheumatologic	○	Eating Disorders	○	On Dialysis
○	Barrett's Esophagus	○	Endometriosis	○	Liver Disease
○	Bleeding Disorder	○	Frequent Bladder Infections	○	Osteoporosis
○	Bowel obstruction	○	GERD/Hiatal Hernia	○	Nerve/Muscle Disorder
○	Crohn's Disease	○	Heart Disease	○	Pace maker
○	COPD/Emphysema	○	Heart Attack	○	Pancreatitis
○	Using Home Oxygen?	○	Heart Failure	○	Previous Stroke
○	Colon Polyps	○	Heart Murmur	○	Rheumatic Fever
○	Colon/Rectal Cancer	○	High Blood Pressure	○	Seizure Disorder
○	Cancer - Breast	○	High Cholesterol	○	Sleep Apnea
○	Cancer - Lung	○	H-Pylori infection	○	Thyroid Disorders
○	Cancer - Kidney	○	Hemorrhoids	○	Ulcerative Colitis
○	Cancer – Pancreas	○	Hepatitis B	○	Valve Replacements
○	Cancer – Stomach/Esophagus	○	Hepatitis C	○	Other

Consent to Import Medication History	
○	Yes, I give Regional Digestive Consultants, PA to electronically check my prescription history

List your current medications or you may submit a separate medication list. ☐**None**
(include over the counter medications such as Aspirin, Tylenol, anti-inflammatory drugs, Iron pills, vitamins, laxatives, enemas, herbs, dietary supplements, diet pills or alternative therapies). Add pages as needed

Medication/Dosage/Frequency (Example: Protonix/40 mg/ once daily)

Allergies/Intolerances

☐ Patient has no known allergies ☐ Patient has no known drug allergies

○	Iodine & Iodide containing products	○	Latex	○	Penicillin
○	Propofol	○	Sulfa	○	Egg
○	Adhesive Tape	○	Reglan (metoclopramide)	○	Erythromycin
○	Codeine Sulfate	○	Shellfish	○	Others

Adult – Past Immunizations: (Indicate past immunizations, and approximate date of last injection)

Flu (most recent	○	Approx. Date:__________	○ Never
Pneumonia (most recent)	○	Approx. Date:__________	○ Never
Tdap (tetanus booster)	○	Approx. Date:__________	○ Never
Hepatitis A	○	Approx. Date:__________	○ Never
Hepatitis B	○	Approx. Date:__________	○ Never
Shingles (Zostavax)	○	Approx. Date:__________	○ Never
Date of Last PPD	○	Approx. Date:__________	○ Never
Date of last T-SPOT TB test	○	Approx. Date:__________	○ Never
Varicella (Chicken Pox)	○	Approx. Date:__________	○ Never

Diagnostic Studies / Previous GI Evaluations

Have you ever had the following tests? Select the time frame

	Never	Yes	Year	Common Result
Flex Sigmoidoscopy	○	○		○ Normal ○ Abnormal ○ Unknown
Barium Enema	○	○		○ Normal ○ Abnormal ○ Unknown
Colonoscopy	○	○		○ Normal ○ Abnormal ○ Unknown
Upper Endoscopy	○	○		○ Normal ○ Abnormal ○ Unknown
Upper GI X-Ray Series	○	○		○ Normal ○ Abnormal ○ Unknown
ERCP	○	○		○ Normal ○ Abnormal ○ Unknown
Capsule Endoscopy	○	○		○ Normal ○ Abnormal ○ Unknown
Abdominal ultrasound	○	○		○ Normal ○ Abnormal ○ Unknown
CT Abdomen/Pelvis	○	○		○ Normal ○ Abnormal ○ Unknown
MRI Abdomen/Pelvis/MRCP	○	○		○ Normal ○ Abnormal ○ Unknown

Bone Density Test (DXA)				Normal Abnormal Unknown
Others				Normal Abnormal Unknown

Surgical History					
None					
Please mark and list the year of surgery					
	Appendectomy		Esophagectomy		Heart Bypass (CABG)
	Colon Resection		Exploratory Laparotomy		Heart Valve replacement
	Gall bladder/Cholecystectomy		Hemorrhoidectomy		Heart Stents
	Gastric Bypass		Hiatal Hernia Repair		Pacemaker/ Defibrillator
	Gastric Sleeve		Hernia Repair/Inguinal/umbilical		Liver Biopsy
	Gastrectomy		Hysterectomy		Liver Transplant
	Gastric Lap Band		Small Bowel Resection		Kidney Transplant
	Other		Stomach/duodenal ulcer surgery		Other

Hospitalizations in the last 3 years None Yes, If yes, complete the following		
Date:	Reason:	Hospital:
Date:	Reason:	Hospital:
Date:	Reason:	Hospital:
Date:	Reason:	Hospital:

Family History

Have you or any of your blood relatives hand any of the following? If yes, please list their relation and age at diagnosis.

Is Family history unknown due to: Adoption No knowledge of my family history

No Family History of Colon Cancer Colon Polyp

	Mother	Father	Brother	Sister	Son	Daughter	Grand Father	Grand Mother	Other
Bleeding Disorder									
Breast Cancer									
Esophageal Cancer									
Celiac Disease									
Colon Polyps									
Colon/Rectal Cancer									
Crohn's Disease									
Cystic Fibrosis									
Diabetes									
Heart Problems									
Hemochromatosis									
Liver Disease									
Ovarian/Uterine cancer									
Pancreatic Cancer									
Pancreatitis									
Stomach Cancer									
Ulcerative Colitis									
Lynch Syndrome									

Other	O	O	O	O	O	O	O	O	O

Social History (Check all that apply)
Marital Status O Single O Married O Divorced O Widowed O Other
Current Occupation
Stress Issues O Work O Recent Trauma O Illness in Family O Relationship issues O Family Issues
Tobacco Smoking Status
O Never Smoked O Former Smoker O Smoke some days O Smoke every day O Exposed to second hand smoke
If you smoke or used to smoke, how many packs do/did you smoke per day? Packs/Day: ____ No. of Years:
If you quit, when did you quit? _______________
Smokeless Tobacco Status
Do you use "smokeless tobacco"?
O Never used O Former user O Current user
If you quit, when did you quit? _______________
Are you ready to quit smoking and / or using smokeless tobacco? O Yes O No
Alcohol Use?
O None O Former - When did you stop? ___________ Current user
O Current user Type _______________ How often? _________________
Caffeine Use?
O None O Occasionally O Daily Intake: _______________
Illegal Drugs
O None O Former O Current How often? _______________ Type: ____________________
IV Drug Use
O Never Previous User O Current
Tattoos
O Yes No
History of Blood/Blood product Transfusions
O No Yes If Yes, approximate dates?
Do you get regular exercise?
O No Yes If Yes, what kind of exercise? _________________________ How often? ______________
Do you follow any special diets?
O No Yes If Yes, what type of diet? _________________________

Review of Systems

Allergic/Immunologic

☐ None	Y	N
Persistent Infections	○	○
Strong allergic reactions	○	○
Immunodeficiency	○	○

Cardiovascular ○ ○

☐ None	Y	N
Chest Pain	○	○
Irregular heartbeat	○	○
Palpitations	○	○
Ankle swelling	○	○

Constitutional

☐ None	Y	N
Fatigue	○	○
Fever	○	○
Pregnant currently	○	○
Unexplained Weight loss	○	○

ENT

☐ None	Y	N
Loose teeth	○	○
Recur Sinus infections	○	○
Nose bleeds	○	○
Hearing loss	○	○

Eyes

☐ None	Y	N
Double vision	○	○
Loss of vision	○	○

Endocrine

☐ None	Y	N
Cold intolerance	○	○
Heat intolerance	○	○
Hair loss	○	○
Excessive thirst	○	○

Gastrointestinal

☐ None	Y	N
Acid Regurgitation	○	○
Abdominal Pain	○	○
Belching	○	○
Black Tarry stools	○	○
Bloating	○	○
Constipation	○	○
Change in bowel habits	○	○
Diarrhea	○	○
Difficult or painful swallowing (food or liquid becomes stuck)	○	○
Fecal incontinence	○	○
Heartburn	○	○
Hemorrhoid problems	○	○
Jaundice	○	○
Nausea	○	○
Poor appetite	○	○
Rectal bleeding	○	○
Vomiting	○	○
Special Diet	○	○

Genitourinary

☐ None	Y	N
Frequent UTI	○	○
Blood in Urine	○	○
Pain on Urination	○	○
Kidney stones	○	○

Hematologic/Lympatic

☐ None	Y	N
Bleeding tendency	○	○
Swollen lymph nodes	○	○
Easy bruising	○	○

Integumentary

☐ None	Y	N
Current skin rash	○	○
Itching	○	○
Skin nodule	○	○
Skin Ulcer	○	○

Musculoskeletal

☐ None	Y	N
Arthritis	○	○
Back Pain	○	○
Muscle Disease	○	○
Neck pain	○	○

Neurological

☐ None	Y	N
Black out spells	○	○
Migraines	○	○
Numbness	○	○
Seizures	○	○
Memory Loss	○	○
Weakness	○	○

Psychiatric

☐ None	Y	N
Anxiety	○	○
Alcoholism	○	○
Bipolar disorder	○	○
Depression	○	○
Panic attacks	○	○

Respiratory

☐ None	Y	N
Chronic cough	○	○
Hoarseness	○	○
Shortness of breath	○	○
Wheezing	○	○
Sleep apnea	○	○

Consent to Share Date

I consent to having my medical and demographic information shared with other health care entities

☐ Yes ☐ No

Reminder Preference: I would like to receive preventive care and follow up care reminders ☐Yes ☐No

Reviewed with ☐ Patient ☐ Parent ☐ Guardian

Signature & Date:____________________ **Physician's Signature & Date**:____________________