Rockville Internal Medicine Group
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Practice Limited to Gastroenterology

GASTROENTEROLOGY NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Date: ____________________

Print Patient Name: ____________________________________ **Date of Birth:** _____________
Last First MI
Gender: Male Female
Married/Partner: Yes No
Children: Yes No

(mark preferred # with an *)
Address: ______________________________ Home Phone #: ___________________
______________________________ Cell Phone #: ___________________
______________________________ Work Phone #: ___________________
Email: ________________________________

Emergency Contact Name: ______________________________ Contact Phone #: _________________
Relationship to Patient: ________________________

Occupation: ____
Referred By: ____
State Reason for your visit to the Gastroenterologist:
____
____

HISTORY OF GASTROINTESTINAL ILLNESS

(Mark any you have had or currently have)

___Colon Polyps ___Abdominal Pain ___Stomach Ulcer ___Rectal Bleeding
___Colon Cancer ___Nausea ___Duodenal Ulcer ___Black Stools
___Diarrhea ___Vomiting ___Gallstones ___Hemorrhoids
___Constipation ___Heartburn ___Pancreatitis ___Hepatitis
___Diverticulosis ___Bloating ___Crohn's Disease ___Liver Disease
___Unexplained Weight Loss ___Belching ___Regurgitation ___Ulcerative Colitis
___Difficulty Swallowing ___Gas ___Food Intolerance ___Gastritis

REVIEW OF SYSTEMS

(Mark any you CURRENTLY have)

___Unintentional Weight Loss ___Eye Inflammation ___Mouth Lesions ___Chest Pain
___Chronic Cough ___Food Allergies ___Anemia ___Arthritis
___Skin Lesions ___Burning on Urination

Print Patient Name: ____________________________________ **Date of Birth:** _____________

Last First MI

PREVIOUS GASTROINTESTINAL TEST

(Give dates of any of the following test you have had)

Hemoccult Cards: ____________________
Colonoscopy: ______________________
Barium Enema: ______________________
Abdominal Sonogram: _________________
CAT Scan: __________________________

Flexible Sigmoidoscopy: ____________________
Upper Endoscopy (EGD): ___________________
Upper GI Series (X-ray): ____________________
Pelvic Sonogram: __________________________
Other: __________________________________

FAMILY HISTORY OF GASTROINTESTINAL ILLNESS

(Indicate any illness your relatives have had and list which relative)

Colon Cancer: __________________________
Colon Polyps: __________________________
Colitis: ________________________________
Crohn's Disease: ________________________
Peptic & Stomach Ulcers: _________________
Gallbladder Disease: _____________________

Diverticulitis: ____________________________
Liver Disease: ____________________________
Hepatitis: ________________________________
Pancreatic Disease: ________________________
Other: ___________________________________
____

PAST MEDICAL HISTORY

(Please list any conditions such as diabetes, high blood pressure, heart disease, etc.)

____
____
____
____

(Please list any surgeries or hospitalizations – include the year)

____
____
____
____

Print Patient Name: ___________________________________ **Date of Birth:** _____________

Last First MI

MEDICATIONS

(Please list any medications (prescription and over the counter) that you are currently taking)

____

____

____

____

____

____

DRUG ALLERGIES

____

____

____

____

DO YOU SMOKE? NO YES FORMERLY Maximum packs per day _____ Number of Years_____ When Quit ______

DO YOU DRINK ALCOHOL? NO YES If yes, how many drinks per week? ________

HOW WOULD YOU LIKE TO BE CONTACTED WITH TEST RESULTS, LAB RESULTS, ETC?

Telephone #: _______________________________ May we leave a message on a machine? YES NO

May we leave a message with a spouse or relative? YES NO

Email address: ____________________________ YES NO

Patient Signature: ____ Date: ___________________

OR

Guardian Signature: ____ Date: ___________________

Physician Signature/ Date: ____