UR MEDICINE | THOMPSON HEALTH

Thompson Health Gastroenterology-Hepatology

Jeffrey A. Goldstein, MD

New Patient Questionnaire

Name: ______________________________________ Date of Birth: _____/______/_____

Referred By: ____

Primary Care Physician: ______________________________

Preferred Pharmacy: _________________________________

YOUR FIRST VISIT

What is the main reason for your scheduled appointment?

____

ALLERGIES

Allergic to Latex? ______ Yes ______ No
Allergic to X-Ray Contrast Dye? □ Yes □ No
Are you allergic to Demerol, Fentanyl, Valium, Versed or Lidocaine? □ Yes □ No
Check if **no known** allergies: □

Medication	Reaction

CURRENT MEDICATIONS *List all current prescription and over-the-counter medications as well as any herbal supplements. If additional space is needed you may attach a separate medication list.*

Medication	Dose

SURGERIES *Please list any past surgeries*

Operation		Year

Part of F.F. Thompson Hospital

SOCIAL HISTORY

Do you smoke? □ Yes □ No

If so, how much? _________________ Since what age? _________

If you've quit, when? ____________ How many years smoked? _______

Do you use alcohol? □ Yes □ No

If yes, how many drinks a day?________OR week? _______

PERSONAL MEDICAL HISTORY

Do you have a history of any of the following?

- ☐ Angina
- ☐ Emphysema/Bronchitis
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Prosthetic Heart Valve
- ☐ Mitral Valve Prolapse
- ☐ Heart Valve Infection
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hypertension
- ☐ Asthma
- ☐ Arthritis
- ☐ Diabetes
- ☐ Other:________________

Comments:____

____

FAMILY HISTORY

Please check the box if you have a family member with a history of the following:

✓	Cancer	Relationship	✓	Illness	Relationship
	Breast			Heart Disease	
	Ovarian			Kidney Problems	
	Colon/Rectal			Ulcerative Colitis	
	Stomach			Crohn's Disease	
	Other:			Bleeding Problems	

Other:____

____

SYMPTOM SCREENER *Please mark the applicable box*

SYMPTOM	NEVER	PAST YEAR	NOW	SYMPTOM	NEVER	PAST YEAR	NOW
Weight Loss				Chest Pain			
Fever				Rapid/Irregular Heartbeats			
Fatigue				Nausea			
Night Sweats				Vomiting			
Change in Sleeping Habits				Change in Bowel Habits			
Change in Appetite				Constipation			
Skin Rash				Diarrhea			
Bruise Easily				Rectal Bleeding			
Excessive Bleeding				Abdominal Pain			
Visual Disturbances				Weakness			
Nosebleed				Joint Pain/Stiffness			
Headaches				Muscle Cramps			
Seizures				Swollen Leg Veins			
Neck Lumps				Fainting Spells			
Difficulty Swallowing				Insomnia			
Heart Burn				Anxiety			
Cough				Suicidal Thoughts			
Wheezing				Loss of Sense of Smell			
Sputum Production (Phlegm)				Difficulty/Painful Urination			
Shortness of Breath				Cool/Whitening of the Fingers			