GASTROENTEROLOGY PATIENT QUESTIONNAIRE

Height:_____ **Weight:**_____

Why were you referred to Dr. Oliver?:_____

Please answer the following questions and describe any positive symptoms. You may use the back of this sheet if necessary. You can circle the appropriate answers.

1. Are you having **Abdominal pain**? _____Yes _____No
   A) If yes, location: upper_____lower_____left side_____ right side_____ middle _____
   B) Any special time of day or night?_____
   C) Any radiation of pain to the Back? _____ Chest?_____ Shoulders?_____
   D) Any relation to meals? _____Yes _____No
   E) How long does it usually last? _____
   F) How severe does it get on a 0 to 10 Scale: 0 is none, 10 is Worst:_____
2. Is **Gas** a problem? _____Yes _____No
3. Any **Heartburn** (burning up the middle of the chest)? _____Yes _____No
4. Any **Nausea** or **Vomiting**? _____Yes _____No
   If yes, is there blood in the vomitus _____Yes _____No
5. Any difficulty **Swallowing**? _____Yes _____No
6. How long have you had the above symptoms?_____
   What makes these symptoms better? _____
   What makes these symptoms worse? _____
7. Is your **Appetite:** Increased? _____ Decreased?_____Unchanged?_____
8. Has your **Weight** changed? _____ How much?_____ □Up(↑) or □Down(↓) How fast?_____
9. A) Any **constipation**? _____Yes _____No
   B) Any **diarrhea**? _____Yes _____No
   C) How often are your bowel movements?_____ How many at night?_____
   D) Any **blood** in stools? _____Yes _____No
   E) Any **black** tarry stools? _____Yes _____No
   F) How long have you had these symptoms?_____

1. Any headaches? _____Yes _____No
   If yes, describe: _____
2. Any dizziness? _____Yes _____No
   If yes, describe:_____
3. Any trouble with eyes, ears, nose or throat? _____Yes _____No
   If yes, describe: _____
4. Any cough? _____Yes _____No
5. Do you get **chest pain** with exercise? _____Yes _____No
   with meals? _____Yes _____No
6. Any **shortness of breath** at rest? _____ With exertion? _____ At night? _____
7. Any difficulty **passing urine**? _____Yes _____No
   Any **Blood** in the urine? _____Yes _____No
   How many times do you get **up at night** to pass urine? _____
8. When was your **Last Menstrual Period**?_____
   Any difficulties with your **Periods**? _____

9. Any weakness in arms or legs? _____Yes _____No
   If yes, describe: _____
10. Any pain in arms or legs? _____Yes _____No
    If yes, describe: _____

1. List all previous **SURGERIES:** _____
   _____
   _____
   Any problems with **Anesthesia?** _____
2. List any other **Hospitalizations:** _____
   _____
3. List any major **accidents** or **injuries**: _____
   _____
4. Do you have diabetes _____, high blood pressure _____, any heart conditions _____,
   kidney disease_____, liver problems _____, hepatitis_____, bleeding tendencies _____
   asthma_____, sleep apnea_____.
   Describe any other conditions: _____
   _____
5. List all **ALLERGIES** to medications and other things: _____
6. List ALL present **MEDICATIONS, SUPPLEMENTS, VITAMINS, PAIN RELIEVERS:** _____
   _____
   _____
   _____
   Do you take any **BLOOD THINNERS (aspirin, Plavix, Coumadin, Warfarin, Aggrenox)** _____
7. Have any **BLOOD Relatives** had any of the following problems: _____Yes _____No
   If yes, specify who: _____
   Colon Polyps: _____
   Colon Cancer: _____
   Colitis: _____
   Crohn's Disease: _____
   Celiac Disease: _____
   Gall Bladder problems: _____
   Liver Disease: _____
   Pancreas problems: _____
   Weight problems: _____
8. How much do you **Smoke**? _____ How many years? _____
   How much **Alcohol** do you drink? _____ How many years? _____
   How much of these **dairy** products do you use?
   - □ Ice cream: _____
   - □ Milk: _____
   - □ Yogurt: _____
   - □ Sour cream: _____
   - □ Cheese: _____