

**PATIENT HISTORY QUESTIONNAIRE**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_

Primary Care Physician (Family Doctor) \_\_\_\_\_

Referring Physician (Who referred you to us?) \_\_\_\_\_

Problem you wish to discuss with the doctor: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

How often do you have bowel movements? \_\_\_\_\_

Do you use laxatives? ..... YES NO

If YES, what kind? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever noticed any rectal bleeding? ..... YES NO

Do you have any rectal pain? ..... YES NO

Do you have any rectal burning? ..... YES NO

Do you have any constipation? ..... YES NO

Have you noticed a change in your bowel movements? ..... YES NO

Do you or your family members have a history of colon cancer or colon polyps?  
YES NO

If YES, Who? Cancer \_\_\_\_\_ Polyps \_\_\_\_\_

Are you aware of any bleeding disorders with yourself? ..... YES NO

Are you aware of any bleeding disorders with your family? ..... YES NO

Do you take blood thinners, such as aspirin or Coumadin? ..... YES NO

Do you have any artificial joints, heart valves, prosthesis? ..... YES NO

Have you ever smoked? ..... YES NO

If YES, how much? \_\_\_\_\_ How long? \_\_\_\_\_ Did you quit? \_\_\_\_\_ When? \_\_\_\_\_

Do you drink alcoholic beverages? ..... YES NO

If YES, how much? \_\_\_\_\_ How often? \_\_\_\_\_

List any surgeries you have had: \_\_\_\_\_

Have you ever had a colonoscopy? ..... YES NO

If YES, when? \_\_\_\_\_ Findings? \_\_\_\_\_

List any medical problems you may have: \_\_\_\_\_

Do you have any cultural or religious concerns regarding your care or treatment  
(i.e. blood transfusions) ..... YES NO

**FEMALE ONLY**

How many pregnancies have you had? \_\_\_\_\_ Vaginal deliveries? \_\_\_\_\_  
C-Sections \_\_\_\_\_ Abortions \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

**PLEASE COMPLETE REVERSE SIDE**

**PATIENT HISTORY QUESTIONNAIRE cont'd**

**Please circle YES or NO if you have any of the following problems**

**CONSTITUTIONAL**

General good health      YES      NO  
 Recent weight change      YES      NO  
 Night sweats/fever      YES      NO  
 Fatigue      YES      NO

**EARS/NOSE/THROAT/MOUTH**

Hearing loss / ringing      YES      NO  
 Sinus problems      YES      NO  
 Nosebleeds      YES      NO  
 Sore throat/voice change      YES      NO

**INTEGUMENTARY (skin/breast)**

Change in hair/nails      YES      NO  
 Rashes/itching      YES      NO  
 Breast lump      YES      NO  
 Breast pain/discharge      YES      NO

**CARDIOVASCULAR**

Chest pain      YES      NO  
 Palpitations      YES      NO  
 Heart attack/stroke      YES      NO  
 Heart murmur      YES      NO  
 Heart disease/angina      YES      NO  
 Mitral valve prolapse      YES      NO  
 Swelling hands/feet      YES      NO

**RESPIRATORY**

Shortness of breath      YES      NO  
 Cough      YES      NO  
 Wheezing/asthma      YES      NO  
 Coughing up blood      YES      NO

**ALLERGIC / IMMUNOLOGIC**

Food allergies      YES      NO  
 Aspirin allergies      YES      NO  
 Antibiotic allergies      YES      NO  
 if yes, \_\_\_\_\_

**MUSCULOSKELETAL**

Muscle pain/cramps      YES      NO  
 Stiffness/swelling joints      YES      NO  
 Joint pain      YES      NO  
 Trouble walking      YES      NO

**NEUROLOGICAL**

Frequent headaches      YES      NO  
 Paralysis/tremors      YES      NO  
 Convulsions/seizures      YES      NO  
 Numbness/tingling      YES      NO  
 Glasses/contacts      YES      NO  
 Blurred/double vision      YES      NO  
 Eye disease/injury      YES      NO  
 Glaucoma      YES      NO

**HEMATOLOGIC / LYMPHATIC**

Bruise easily      YES      NO  
 Slow to heal      YES      NO  
 Enlarged glands      YES      NO

**ENDOCRINE**

Diabetes      YES      NO  
 Excessive thirst/urinating      YES      NO  
 Thyroid Disease      YES      NO  
 Hormone problem      YES      NO

**GASTROINTESTINAL**

Nausea/vomiting      YES      NO  
 Abdominal pain      YES      NO  
 Rectal bleeding      YES      NO  
 Bowel problems

**PSYCHIATRIC**

Insomnia      YES      NO  
 Confusion/memory loss      YES      NO  
 Depression      YES      NO

**GENITOURINARY - MALE ONLY**

Blood in urine      YES      NO  
 Kidney stones      YES      NO  
 Sexual problems      YES      NO  
 Testicular pain      YES      NO

**GENITOURINARY - FEMALE ONLY**

Blood in urine      YES      NO  
 Kidney stones      YES      NO  
 Sexual problems      YES      NO  
 Vaginal pain/burning      YES      NO

Patient statement:      To the best of my knowledge, the above information is accurate and complete.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Physician statement:      I have reviewed the questionnaire with the above mentioned patient in detail.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

