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: _____
_____
_____
Email: _____

Home Phone #: _____
Cell Phone #: _____
Work Phone #: _____

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
___Colon Cancer
___Diarrhea
___Constipation
___Diverticulosis
___Unexplained Weight Loss
___Difficulty Swallowing

___Abdominal Pain
___Nausea
___Vomiting
___Heartburn
___Bloating
___Belching
___Gas

___Stomach Ulcer
___Duodenal Ulcer
___Gallstones
___Pancreatitis
___Crohn's Disease
___Regurgitation
___Food Intolerance

___Rectal Bleeding
___Black Stools
___Hemorrhoids
___Hepatitis
___Liver Disease
___Ulcerative Colitis
___Gastritis

REVIEW OF SYSTEMS

(Mark any you CURRENTLY have)

___Unintentional Weight Loss
___Chronic Cough
___Skin Lesions

___Eye Inflammation
___Food Allergies
___Burning on Urination

___Mouth Lesions
___Anemia

___Chest Pain
___Arthritis

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: _____