Vanderbilt Digestive Disease Center

NEW PATIENT QUESTIONNAIRE

Division of Gastroenterology
and Hepatology

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Pt: Name: _____

Review of Systems: (please circle symptoms that you are or have been suffering from)

General: weight gain, weight loss, fatigue, fever.

Eyes: dry eyes, loss of vision, blurred vision, color blindness.

Ear, nose, mouth, throat: deafness, ear ringing, nose bleed, sore throat, hoarseness, dry mouth.

Cardiovascular: palpitations, chest pain, leg swelling, shortness of breath with activity.

Respiratory: Cough, shortness of breath at rest.

Gastrointestinal: Appetite change, heartburn, indigestion, nausea, vomiting (with or without blood), jaundice, abdominal distension, constipation, diarrhea, bloody stool, black stool.

Urinary: incontinence, frequent urination, painful urination.

Skin: itching, bruising, rash.

Neurological: dizziness, numbness, tingling, tremors.

Psychiatric: confusion, memory loss, depression, hallucination.

Reviewed with Patient _____**M. D.**

Date: _____

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****SPECIFIC REASON FOR THE VISIT:** _____

DRUG ALLERGIES or SENSITIVITY: _____

Primary Care Doctor: _____Phone Number_____

Referring Provider: _____ Phone Number _____

MEDICAL HISTORY (Year and Diagnosis/Problems)

_____

_____

_____

_____

OPERATIONS (Year and Procedure)

_____

_____

_____

_____

FAMILY HISTORY: Have any of your immediate family had any of the following:

Write the appropriate family member beside the condition (father, mother, child, brother, sister, uncle, aunt, grandparent)

Colon Cancer	_____	Thyroid Disease	_____	Rheumatoid Arthritis	_____
Crohn's Disease	_____	Kidney Disease	_____	High Blood Pressure	_____
Ulcerative Colitis	_____	Heart Disease	_____	Auto Immune Disorders	_____
Liver Disease	_____	Lung Disease	_____	Other Cancer	_____

SOCIAL HISTORY:

Tobacco use: **YES NO** Packs per day: _____ How many years: _____ Last use _____
Alcohol use: **YES NO** Amount per day/week/month _____ How many years _____ Last use ___
Drug use: **YES NO** What Type _____ How many years _____Last use _____
Marital Status: _____ Occupation: _____
Number of Children _____ **Do you have a Caregiver?** _____

PREVENTATIVE:

Do you routinely take the flu shot? **YES NO** when was your last flu shot_____
Have you been vaccinated against: Pneumonia: **YES NO,** Hepatitis A: **YES NO,** Hepatitis B: **YES NO**
Have you ever had a colonoscopy? **YES NO** Date of last colonoscopy_____

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Current Medications (to include over the counter drugs)

NAME: _____

Date of Birth: _____

Name of Drug	Dose Strength (such as mg, cc)	Frequency How many times a day?