Patient Questionnaire

Name	
Date of Birth	
Reason for Visit	
Referring Physician	

Medication Allergies

Current medications and dosage	

Medical Problem List	**Previous Surgeries**
	Date of last colonscopy:

Family history of colon cancer? If so, please list relationship:	**Any other family history of medical problems?**

Tobacco use (please circle):	Current smoker/Former/Never	Type: Cigarettes/Cigar/Pipe Smokeless tobacco: Current user/Former/Never
	Ready to quit? Yes/No	
Alcohol Use: How many per week?	_____ Glasses of Wine	_____ Cans of beer _____ Shots of liquor

Systems Review: Please circle for your answer

Constitutional			**Eyes**			**Gastrointestinal**			**Endo/Heme**		
Fever	Y	N	Blurred vision	Y	N	Heartburn	Y	N	Easy bruising	Y	N
Chills	Y	N	Double vision	Y	N	Nausea	Y	N	Allergies	Y	N
Weight loss	Y	N	Light sensitivity	Y	N	Vomiting	Y	N	Excessive thirst	Y	N
Fatigue	Y	N	Eye pain	Y	N	Abdominal pain	Y	N	**Neurologic**		
Sweating	Y	N	Eye discharge	Y	N	Diarrhea	Y	N	Dizziness	Y	N
Weakness	Y	N	Eye redness	Y	N	Constipation	Y	N	Tingling	Y	N
Skin			**Heart**			Blood in stool	Y	N	Tremor	Y	N
Rash	Y	N	Chest pain	Y	N	Black stool	Y	N	Change in sensation	Y	N
Itching	Y	N	Irregular heart beat	Y	N	**Urinary**			Speech Change	Y	N
Ear, Nose and Throat			Shortness of breath when lying down?	Y	N	Painful urination	Y	N	Weakness	Y	N
Headaches	Y	N	Pain in legs when walking	Y	N	Urgency to urinate	Y	N	Seizures	Y	N
Hearing loss	Y	N	Leg swelling	Y	N	Frequent urination	Y	N	Loss of consciousness	Y	N
Ringing in ears	Y	N	Waking up with shortness of breath?	Y	N	Blood in urine	Y	N	**Psychiatric**		
Ear pain	Y	N	**Lungs**			Flank pain	Y	N	Depression	Y	N
Ear discharge	Y	N	Cough	Y	N	**Musculoskeletal**			Thoughts of suicide	Y	N
Nosebleeds	Y	N	Coughing up blood	Y	N	Muscle pain	Y	N	Substance abuse	Y	N
Congestion	Y	N	Coughing up phlegm	Y	N	Neck pain	Y	N	Hallucinations	Y	N
Noisy breathing	Y	N	Shortness of breath	Y	N	Back Pain	Y	N	Anxiety	Y	N
Sore throat	Y	N	Wheezing	Y	N	Joint pain	Y	N	Insomnia	Y	N
						Falls	Y	N	Memory loss	Y	N