# GASTROENTEROLOGY QUESTIONNAIRE

Name _____ Date _____

DOB _____ Age _____

Referring Physician _____

**Current gastrointestinal problems/reason for visit** _____

_____

_____

_____

**Past medical problems** _____

_____

_____

_____

**Date of last colon exam** _____

**Have you had any of the following?** (Any left blank will be considered negative in your medical record.)

- ❑ hypertension
- ❑ diabetes
- ❑ heart disease
- ❑ kidney disease
- ❑ arthritis
- ❑ lupus

**For Hepatitis Patients:**

Please check all that apply

- ❑ Blood transfusion prior to 1992?
- ❑ Tattoos?
- ❑ Ever had abnormal liver enzymes prior to being told you had hepatitis?
- ❑ Ever donated blood? If yes, when _____
- ❑ Did the blood bank inform you of abnormal lab?
- ❑ Ever used IV drugs or cocaine? If yes, when used last _____

**Past Surgical History:**

| Operation | Where and When |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Current Medications:** List all medications you currently take. Please include over the counter medications.

_____

_____

_____

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**Allergies:** List any drugs you cannot take.

_____

_____

_____

_____

**Family Health History:**

Medical Condition(s)

Mother _____

Father _____

Brother(s) _____

Sister(s) _____

Children _____

Anyone in the family with liver disease, colon polyps, colon cancer, pancreatic cancer, stomach cancer, sprue, Crohn's disease, or ulcerative colitis?

_____

_____

_____

**Social History:**

Marital status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Number of Children and Ages _____

Occupation _____

**Habits:**

Tobacco use? ❑ Current Smoker-Everyday (indicate how much) _____ ❑ Current Smoker-occasional_____

❑ Former Smoker ❑ Never Smoked ❑ Smoker-current status unknown ❑ Unknown if ever smoked

Alcohol use? ❑ Yes ❑ No If yes, approximately how much do you drink?_____

Recreational or illicit drug use? ❑ Yes ❑ No Which substance(s)? _____

**Gastrointestinal Review:**

Have you had or do you have any of the following? If yes, please indicate when in the space provide below. Please answer each question. Any left blank will be considered negative in your medical record.

- ❑ Jaundice
- ❑ Ulcers
- ❑ Vomiting blood
- ❑ Black bowel movements
- ❑ Diarrhea
- ❑ Blood with bowel movements
- ❑ Heartburn more than twice weekly?
  How many years?_____
- ❑ Difficulty swallowing
- ❑ Painful swallowing
- ❑ Abdominal cramping/bloating
- ❑ Weight change
  Weight one year ago _____

_____

_____

**- next page -**

# GASTROENTEROLOGY PATIENT QUESTIONNAIRE

Completion of this form will help you recall information your doctor needs in evaluating your health and will serve as a guide for your doctor in obtaining your medical history.

Name _____Date _____Date of Birth _____

Check "yes" to any of the following symptoms you have been experiencing recently. Please answer each question. Any checked "no" or left blank will be considered negative in your medical record.

**YES or NO**

**Constitutional**

- ❑ ❑ Chills
- ❑ ❑ Fever
- ❑ ❑ Fatigue and/or weakness
- ❑ ❑ Weight Loss

**Ear, Nose & Throat**

- ❑ ❑ Double Vision
- ❑ ❑ Ear Infections
- ❑ ❑ Eye Pain
- ❑ ❑ Nasal Congestion
- ❑ ❑ Sinus Infection
- ❑ ❑ Sore Throat

**Respiratory**

- ❑ ❑ Difficulty breathing
- ❑ ❑ Frequent Cough
- ❑ ❑ Chest pain associated with breathing or coughing
- ❑ ❑ Wheezing

**Cardiovascular**

**YES NO**

- ❑ ❑ Chest Pain
- ❑ ❑ Swelling in Extremities
- ❑ ❑ Palpitations

**YES or NO**

**Gastrointestinal**

- ❑ ❑ Abdominal Pain
- ❑ ❑ Change in Bowel Habits
- ❑ ❑ Constipation
- ❑ ❑ Diarrhea
- ❑ ❑ Heartburn
- ❑ ❑ Blood in Vomit
- ❑ ❑ Blood in Stool
- ❑ ❑ Loss of Appetite
- ❑ ❑ Black or Tarry Stools
- ❑ ❑ Nausea
- ❑ ❑ Reflux
- ❑ ❑ Vomiting

**Genitourinary**

- ❑ ❑ Pain with urinating
- ❑ ❑ Blood in urine
- ❑ ❑ Urine frequency
- ❑ ❑ Urine incontinence
- ❑ ❑ Urine retention

**Reproductive**

- ❑ ❑ Penile discharge
- ❑ ❑ Sexual Dysfunction

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# GASTROENTEROLOGY PATIENT QUESTIONNAIRE

Check "yes" to any of the following symptoms you have been experiencing recently. Please answer each question. Any checked "no" or left blank will be considered negative in your medical record.

**YES or NO** **YES or NO**

**Metabolic/Endocrine**

- ❑ ❑ Cold Intolerance
- ❑ ❑ Excessive Thirst
- ❑ ❑ Heat Intolerance
- ❑ ❑ Swelling of breast tissue (male)

**Neurological**

- ❑ ❑ Dizziness
- ❑ ❑ Headache
- ❑ ❑ Numbness
- ❑ ❑ Tremors
- ❑ ❑ Vertigo

**Psychiatric**

- ❑ ❑ Anxiety
- ❑ ❑ Depression
- ❑ ❑ Increased Stress

**Skin**

- ❑ ❑ Contact Allergies
- ❑ ❑ Hives
- ❑ ❑ Itching
- ❑ ❑ Rash

**Musculoskeletal**

- ❑ ❑ Back Pain
- ❑ ❑ Muscle Pain
- ❑ ❑ Joint Pain

**Hematologic/Lymphatic**

- ❑ ❑ Easy Bleeding
- ❑ ❑ Easy Bruising
- ❑ ❑ Swollen Lymph nodes

**Immunologic**

- ❑ ❑ Asthma
- ❑ ❑ Chemicals in workplace
- ❑ ❑ Food allergies
- ❑ ❑ Compromised Immune system
- ❑ ❑ Seasonal Allergies

**Please note any comments below regarding symptoms that you are experiencing:**

_____

_____

_____

_____

_____

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## APPOINTMENT CANCELLATION POLICY

MANA Gastroenterolgy requires a 24-hour notice for cancellation of appointments. Please note there will be a **$25.00 fee** charged to the patient if the appointment is not cancelled 24-hours prior.

If you have an emergency, please let us know and the fee may be waived.

I have read and understand this policy.

PRINT NAME: _____ D.O.B.: _____

PATIENT SIGNATURE: _____ DATE: _____

HOME PHONE #_____ CELL PHONE # _____

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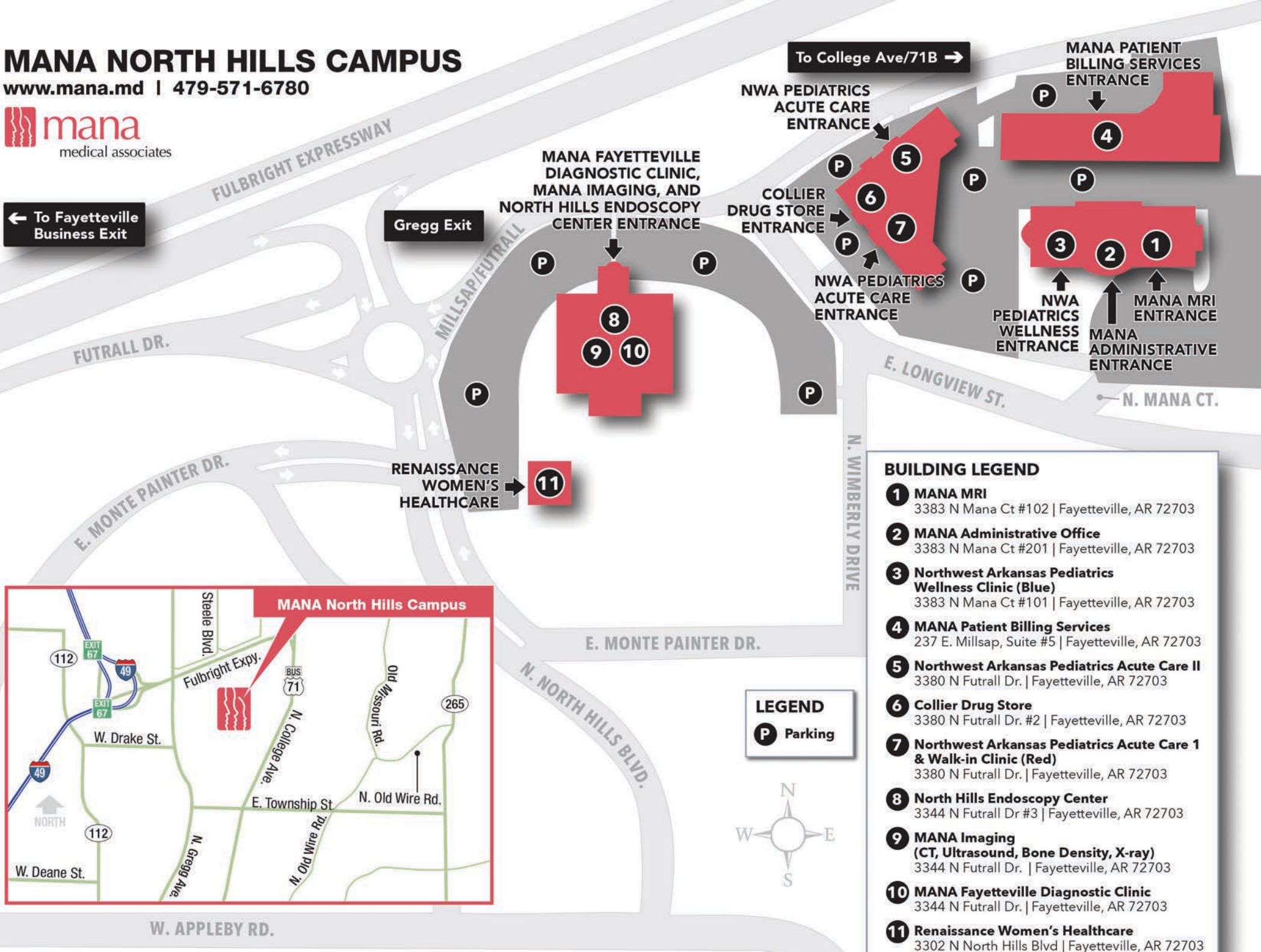





## LEGEND

P Parking

## BUILDING LEGEND

1. **MANA MRI**
   3383 N Mana Ct #102 | Fayetteville, AR 72703
2. **MANA Administrative Office**
   3383 N Mana Ct #201 | Fayetteville, AR 72703
3. **Northwest Arkansas Pediatrics Wellness Clinic (Blue)**
   3383 N Mana Ct #101 | Fayetteville, AR 72703
4. **MANA Patient Billing Services**
   237 E. Millsap, Suite #5 | Fayetteville, AR 72703
5. **Northwest Arkansas Pediatrics Acute Care II**
   3380 N Futrall Dr. | Fayetteville, AR 72703
6. **Collier Drug Store**
   3380 N Futrall Dr. #2 | Fayetteville, AR 72703
7. **Northwest Arkansas Pediatrics Acute Care 1 & Walk-in Clinic (Red)**
   3380 N Futrall Dr. | Fayetteville, AR 72703
8. **North Hills Endoscopy Center**
   3344 N Futrall Dr #3 | Fayetteville, AR 72703
9. **MANA Imaging (CT, Ultrasound, Bone Density, X-ray)**
   3344 N Futrall Dr. | Fayetteville, AR 72703
10. **MANA Fayetteville Diagnostic Clinic**
    3344 N Futrall Dr. | Fayetteville, AR 72703
11. **Renaissance Women's Healthcare**
    3302 N North Hills Blvd | Fayetteville, AR 72703