

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
- heart disease
- arthritis
- diabetes
- kidney disease
- 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.

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.

- | | |
|---|---|
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Heartburn more than twice weekly?
How many years? _____ |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Painful swallowing |
| <input type="checkbox"/> Black bowel movements | <input type="checkbox"/> Abdominal cramping/bloating |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Weight change
Weight one year ago _____ |
| <input type="checkbox"/> Blood with bowel movements | |

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

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

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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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:

APPOINTMENT CANCELLATION POLICY

MANA Gastroenterology requires a 24-hour notice for cancellation of appointments. Please note there will be a **\$50.00 fee** for any appointment that is not canceled 24-hours prior. The fee is not covered by insurance.

I have read and understand this policy.

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

PATIENT SIGNATURE: _____ DATE: _____

HOME PHONE # _____ CELL PHONE # _____



MANA NORTH HILLS CAMPUS

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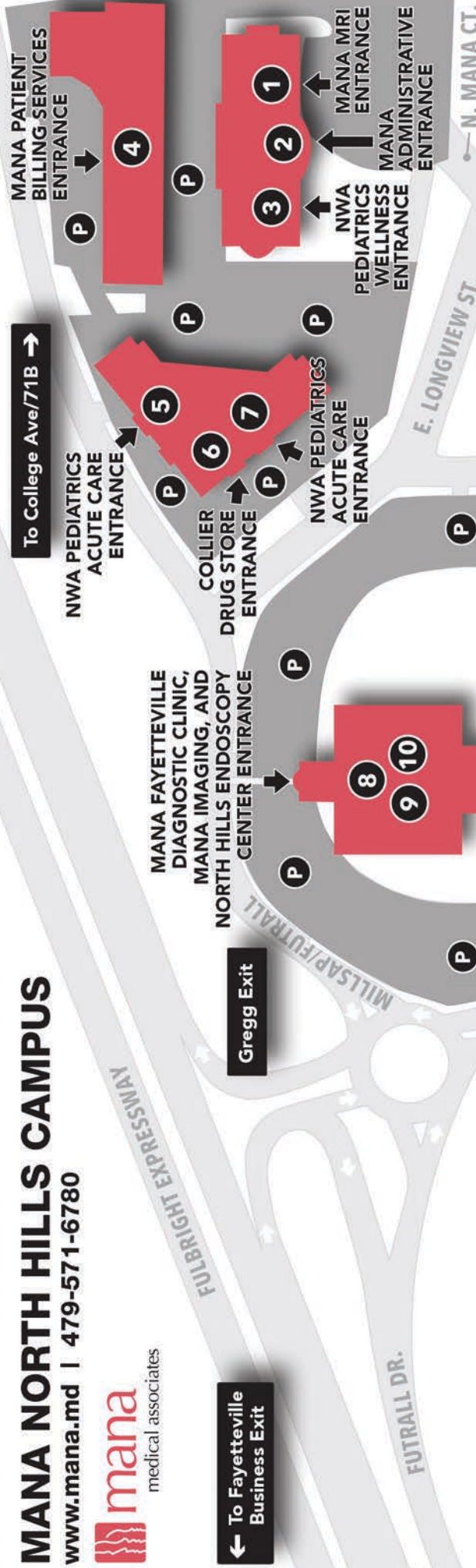


mana
medical associates

← To Fayetteville
Business Exit

Gregg Exit

To College Ave/71B →



N. WIMBERLY DRIVE

E. LONGVIEW ST.

N. MANA CT.

E. MONTE PAINTER DR.

N. NORTH HILLS BLVD.

FULBRIGHT EXPRESSWAY

FUTRALL DR.

E. MONTE PAINTER DR.

RENAISSANCE WOMEN'S HEALTHCARE

MANA FAYETTEVILLE DIAGNOSTIC CLINIC, MANA IMAGING, AND NORTH HILLS ENDOSCOPY CENTER ENTRANCE

NWA PEDIATRICS ACUTE CARE ENTRANCE

COLLIER DRUG STORE ENTRANCE

NWA PEDIATRICS ACUTE CARE ENTRANCE

NWA PEDIATRICS WELLNESS ENTRANCE

MANA MRI ENTRANCE
MANA ADMINISTRATIVE ENTRANCE

MANA PATIENT BILLING SERVICES ENTRANCE

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

LEGEND

P Parking



W. APPLBY RD.