

**Patient Questionnaire**

**Date:** \_\_\_\_\_

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Home phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

I, (**print patient's name**) \_\_\_\_\_ (or guardian of), hereby authorize the following physician (s) and/or institution (s) to release information obtained during the course of my diagnosis and treatment to California Pacific Medical Center and the Interventional Endoscopy Services, 2351 Clay Street., Suite #600; San Francisco, CA 94115. Further, I hereby authorize California Pacific Medical Center and the Interventional Endoscopy Services providers to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand that this agreement will be in effect until I revoke it in writing. A photocopy of these authorizations shall be valid as the original.

**Referring Physician's Name:** \_\_\_\_\_

\*Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*Phone Number: \_\_\_\_\_ \*Fax Number: \_\_\_\_\_

**Primary Care Physician's Name:** \_\_\_\_\_

\*Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*Phone Number: \_\_\_\_\_ \*Fax Number: \_\_\_\_\_

**WHAT IS YOUR MAIN COMPLAINT?** \_\_\_\_\_

**SYSTEMS REVIEW**

Do you experience any of the following?

- |                                      |                                       |  |  |
|--------------------------------------|---------------------------------------|--|--|
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Abdominal pain        |
| <input type="checkbox"/> Bloating    | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nausea        | <input type="checkbox"/> Vomiting              |
| <input type="checkbox"/> Blood in BM | <input type="checkbox"/> Heartburn    | <input type="checkbox"/> Chest pain    | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Itching     | <input type="checkbox"/> Joint pains  | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Shortness of breath   |
| <input type="checkbox"/> Diarrhea    |                                       |  |  |

Provide details/list other symptoms: \_\_\_\_\_

### PAST MEDICAL HISTORY

Have you had any of the following diseases?

- |  |                                    |  |  |
|--|------------------------------------|--|--|
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Blood clots       |
| <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> Asthma    | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Heart failure     |
| <input type="checkbox"/> GI Bleeding             | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Cancer (specify: _____) |                                    |  |  |

Provide details/list other diseases: \_\_\_\_\_

### PAST SURGICAL HISTORY

What operations have you had?

- |                                       |             |             |  |             |             |
|---------------------------------------|-------------|-------------|--|-------------|-------------|
| <input type="checkbox"/> Gallbladder  | Date: _____ | YEAR: _____ | <input type="checkbox"/> Colon           | Date: _____ | YEAR: _____ |
| <input type="checkbox"/> Pancreas     | Date: _____ | YEAR: _____ | <input type="checkbox"/> Stomach         | Date: _____ | YEAR: _____ |
| <input type="checkbox"/> Appendix     | Date: _____ | YEAR: _____ | <input type="checkbox"/> Fundoplication  | Date: _____ | YEAR: _____ |
| <input type="checkbox"/> Hernia       | Date: _____ | YEAR: _____ | <input type="checkbox"/> Hysterectomy    | Date: _____ | YEAR: _____ |
| <input type="checkbox"/> Heart bypass | Date: _____ | YEAR: _____ | <input type="checkbox"/> Transplantation | Date: _____ | YEAR: _____ |

Other: \_\_\_\_\_

### PAST ENDOSCOPIC HISTORY

What prior endoscopies have you had?

- |  |             |                |
|--|-------------|----------------|
| <input type="checkbox"/> Upper endoscopy | Date: _____ | Results? _____ |
| <input type="checkbox"/> Colonoscopy     | Date: _____ | Results? _____ |
| <input type="checkbox"/> ERCP            | Date: _____ | Results? _____ |

### FAMILY MEDICAL HISTORY

Which diseases run in your family?

Cancers:  Esophagus  Stomach  Pancreas  Colon  Liver  Breast

Which relative? \_\_\_\_\_ Age at diagnosis? \_\_\_\_\_

Other diseases:  Ulcers  Pancreatitis  Polyps  Colitis  Diabetes  Bleeding tendency

List any other family illnesses: \_\_\_\_\_

### MEDICATIONS

Which medications are you taking? Please include: Dosage and how many times a day

- |                                     |   |                                   |                                     |  |
|-------------------------------------|---|-----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Aspirin    | <input type="checkbox"/> Plavix         | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Insulin    | <input type="checkbox"/> Oral anti-diabetic    |
| <input type="checkbox"/> Steroids   | <input type="checkbox"/> Non-steroidal  | <input type="checkbox"/> Antacids | <input type="checkbox"/> H2 Blocker | <input type="checkbox"/> Proton pump inhibitor |
| <input type="checkbox"/> Antibiotic | <input type="checkbox"/> Antidepressant | <input type="checkbox"/> Iron     | <input type="checkbox"/> Pain pills | <input type="checkbox"/> Birth control pill    |

Please list all other medication: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DRUG ALLERGIES**

Have you had an allergic reaction to any medication?

- Benzodiazepams       Demerol       Antibiotics (specify)       Contrast agent

List any other drug allergies \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Marital status:     Single       Married       Widowed       Divorced

Number of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

Occupation (current or previous) \_\_\_\_\_

Retired       Disabled

Tobacco:     Never smoked     Quit smoking/date \_\_\_\_\_       Still smoking

< 1 PPD       > 1 PPD      No. of years smoked? \_\_\_\_

Alcohol:     None       Beer       Wine       Mixed drinks

< 1 drink/day     1-2 drinks/day     ≥ 2 drinks/day

Recreational drugs:       marijuana       heroin       cocaine       amphetamines

Others: \_\_\_\_\_