ROCKFORD GASTROENTEROLOGY ASSOCIATES

PATIENT HISTORY QUESTIONNAIRE

To Be Completed By Patient Prior to First Appointment

Name: _____ **Date of Birth:** _____

Primary Care Physician: _____ **Referring Physician:** _____

Preferred Hospital: **Preferred Pharmacy:** _____

Female Patients: Date of Last Period: _____ **Date of Last Pap Smear:** _____
Date of Last Mammogram: _____

Did you receive a copy of RGA's Patient Rights? Yes ___No___

Do you have Advance Directives for healthcare? Yes ___No___ (***Bring Copy to Appt.***)

Caffeine Use: Yes ___No___ How many/day: _____ Alcohol Use: Yes ___No___ Drinks per day: ____ How long: ____

Smoker: Yes ___No___ Packs/day: _____ How long? ____ X-smoker: Yes ☐ Date quit: _____ Packs/day: ____

Have you ever used illicit drugs? Yes ___No___ What? _____ When: _____

Have you ever had any of these? Please give a*pproximate **DATE** received.*

Influenza Vaccine _____ Herpes Zoster (Shingles) Vaccine _____ Pneumonia Vaccine _____

Dexa Scan_____ Hepatitis A Vaccine _____ Hepatitis B Vaccine _____ Last TB test: _____

PRESCRIPTION MEDICATIONS: *Please include Blood Thinners, Diabetes pills & Insulin and Birth Control. Please bring medications with you to your appointment.*

Medication Name	Reason for taking Medication	Dosage - *mg(milligram)*	How Often

NON-PRESCRIPTION MEDICATIONS: Please include aspirin, Advil, Nuprin, Antacids, Laxatives, Herbal products, etc.

Medication Name	Reason for taking Medication	Dosage	How Often

ALLERGIES:

Medication: _____Reaction: _____

Other: _____Reaction: _____

Latex: _____Reaction: _____

Eggs: Yes ___ No ___ Peanuts: Yes ___ No ___ Soy: Yes ___ No ___ Novocaine: Yes ___ No ___

Xray Dye: Yes ___ No ___ Iodine: Yes ___ No ___ Shelfish: Yes ___ No ___

Do you have any of the following symptoms?

SYMPTOM	Yes	No	SYMPTOM	Yes	No	SYMPTOM	Yes	No
Weight Loss			Burning with Urination			Numbness		
Double Vision			Blood in Urine			Anxiety		
Shortness of Breath			Urinary Frequency			Depression		
Cough			Cold/Heat Intolerances			Rash		
Chest Pain			Dizziness			Joint Pain		
Palpitations			Headaches					

PERSONAL MEDICAL ILLNESSES

	Yes	No		Yes	No		Yes	No
Heart Disease/Heart Attack			Asthma			Cancer		
Cardiac Stent/Heart Valve			Rheumatic Fever			Glaucoma		
Heart murmur			Diabetes			Tuberculosis		
High Blood Pressure			Arthritis			Hepatitis		
Epilepsy/Seizures			Artificial Joints			HIV or AIDS		
Pacemaker/Defibrillator			Sleep Apnea			Other_____		

HOSPITALIZATIONS AND SURGERIES

SURGERY	DATE	HOSPITAL	PHYSICIAN

FAMILY HISTORY

Family Member	Alive	Deceased	Ages	Illnesses	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					
Children					
Other Relatives if Significant					
Family history of colon cancer, polyps, ulcerative colitis or Crohn's Disease.					

Have you ever had any of these reactions to anesthesia?
Nausea/Vomiting _____ Fever _____ Difficulty Waking Up _____ Heart Problems _____

Are there any family members that have had any of these reactions to anesthesia?
Nausea/Vomiting _____ Fever _____ Difficulty Waking Up _____ Heart Problems _____

Dentures? Yes ____ No ____

Have you ever had any X-rays, CT Scans, MRI's or Ultrasounds within the last year? No ____ Yes ____
If Yes, where? _____ What for? _____ Date: _____

Have you ever had any blood tests done within the last year? No ____ Yes _____
If Yes, where? _____ What for? _____ Date: _____

RECENT TRAVEL:

Out of State	**Where:**
Out of Country	**Where:**
Travel Exposure	**Where:**

EDUCATION:
High School ____ Tech Training ____ Associated Degree ____ Bachelor's Degree ____ Advanced Degree ____

OCCUPATION: _____ Employment Status: _____ Retired: _____

DOCTOR'S NOTES: (Do not write in this space)