Office Use only	Doctor:	LRDC Chart #:	Appointment Date:

Little Rock Diagnostic Clinic

Gastroenterology

Patient Questionnaire

This information will become part of the medical record and is subject to federal privacy laws.

Full Name: _____ Date of Birth: _____

E-mail address: _____ Cell Phone: _____

Referring physician: _____

Primary Care Physician: _____

Circle all that apply: tobacco use high blood pressure diabetes heart disease

Describe the medical problem or reason that you are here for evaluation today.

_____

_____

_____

_____

When did it start? _____

How long does it last? _____

Where is it located? _____

How severe is it? _____

How often does it occur? _____

Aggravated by? _____

Relieved by? _____

Vitals	This box will be completed by the nursing staff at the Provider's office Please DO NOT write.						
Ht	**WT**	**Temp**	**BP**	**Pulse**	**Resp**	**Pulse ox**	

Please list the medications you are currently taking. Please include all over-the-counter and herbal medications (use back of page if needed):

Medication Name	Dosage	How often	Started	Problem medication for	Doctor who wrote

Pharmacy Name and Address _____

Do you get your medications for 30 days or 90 days at a time? (circle one) **30 days** **90 days**

Please list any drug allergies or side effects (use back page if needed)

When	Drug	Describe Reaction

Immunizations (list date of last)

Tetanus	Pneumonia	Shingles	Flu

List all the physicians that you are currently seeing:

Physician Name	Specialty	Condition being treated	Next Office Visit	**Would you like a copy of your visit sent to this doctor?**

Review of Systems

Please check a box below for every question that applies to your current health

Constitutional	No	Yes
Chills		
Fever		
Tired		
Weight Loss		
Other:		

Head/Neck	No	Yes
Double vision		
Ear infections		
Eye pain		
Nasal congestion		
Sinus infection		
Sore throat		
Other:		

Respiratory	No	Yes
Shortness of breath		
Frequent cough		
Pleuritic pain		
Wheezing		
Other:		

Heart	No	Yes
Chest pains		
Swelling in extremities		
Heart racing		
Other:		

Gastrointestinal	No	Yes
Abdominal pain		
Change in bowel habits		
Constipation		
Diarrhea		
Trouble swallowing		
Heartburn		
Vomiting blood		
Bloody stools		
Loss of appetite		
Black stool		
Nausea		
Reflux		
Vomiting		
Other:		

Urinary	No	Yes
Painful urination		
Blood in urine		
Urinary frequency		
Urinary incontinence		
Urinary retention		
Other:		

Metabolic/ Endocrine	No	Yes
Cold Intolerance		
Excessive thirst		
Heat intolerance		
Other:		

Neurological	No	Yes
Dizziness		
Headache		
Numbness		
Tremors		
Vertigo		
Other:		

Psychiatric	No	Yes
Anxiety		
Depression		
Increased stress		
Other:		

Integumentary	No	Yes
Contact allergy		
Hives		
Pruritus		
Rash		
Other:		

Musculoskeletal	No	Yes
Back Pain		
Muscle pain		
Joint pain		
Other:		

Hematologic/Lymphatic	No	Yes
Easy bleeding		
Easy bruising		
Swollen lymph nodes		
Other:		

Immunologic	No	Yes
Asthma		
Chemicals in work place		
Food Allergies		
Immunosuppression		
Seasonal allergies		
Other:		

Past Medical History

Anemia		Diabetes		Obesity		Varices- esophageal	
Arthritis		Diverticular disease		Pancreatitis		Varices- gastric	
Asthma		Elevated lipids		Parkinson's disease			
Cancer		Hepatitis exposure		Peptic ulcer disease			
Celiac disease		GERD		Polyarteritis nordosa			
Cholelithiasis		Gout		Renal Disease			
Colon polyps		Headache, migraine		Seizure disorder			
Congestive heart failure		Hepatitis, liver disease		Stroke			
COPD		Hypertension		Thyroid disease			
Coronary artery disease		Irritable bowel disease		Ulcerative colitis			
Crohn's disease		Kidney stones					

Past Surgical History

	Year		Year	**Men Only**	Year	**Women Only**	Year
Heart Balloon		Knee Replaced		Prostate Biopsy		Tubal ligation	
Appendix Removal		Liver Biopsy		Prostate Surgery		C-section	
Back Surgery		ORIF		Vasectomy		Hysterectomy	
Blood transfusion		Small Bowel surgery				Mastectomy	
By-pass surgery		Thyroid Removal				TAH/BSO	
Cardiac pacemaker						Vaginal Hyst	
Carpal Tunnel							
Colon resection							
Colostomy							
Gastric Bypass							
Hernia repair							
Hip replacement							

Other: _____

_____

_____

Family History

Place a check mark in the box to all that apply

___ Adopted/unknown

	Mother	Father	Sister	Brother	Other
Alive (age)					
Deceased (at what age)					
Alcoholism					
Alzheimer's disease					
Asthma					
Blood disorders					
Cancer					
Type of cancer					
Cardiovascular disease					
Celiac disease					
Colitis					
Colon polyps					
Coronary artery disease					
Crohn's disease					
Diabetes					
Diverticular disease					
Elevated lipids					
Gallbladder disease					
Genetic disease					
Hypertension					
Irritable bowel syndrome					
Liver disease					
Migraines					
Obesity					
Osteoporosis					
Peptic ulcer disease					
Renal disease					
Seizure disorder					
Stroke					
Thyroid disorder					
Ulcerative colitis					

Other relevant family history:

_____

_____

_____

_____

Social History

Tobacco History:

Smoking Tobacco Use

Tobacco Type:	Use daily	Usage per day	Years used	Age started	Age stopped
☐ Cigarette	☐	____ #packs/cig			
☐ Cigarillo	☐	____ cigarillos			
☐ Cigar	☐	____ cigars			
☐ Pipe	☐	____ pipes			

Non-Smoking Tobacco Use

Tobacco Type:	Use Daily	Usage per day	Years used	Age started	Age stopped
☐ Chewing	☐	____ units			
☐ Smokeless	☐	____ units			
☐ Snuff	☐	____ units			

Have you ever tried to quit smoking? No / Yes Year quit? _____

Cessation method? _____ Longest period tobacco free? _____ Relapsed? Yes / No
If so, why?
_____
_____

Alcohol History:

No____ Yes____ Formerly (list year quit) _____
Type of alcohol _____
How frequently _____
How much a day? _____
When was your last drink? _____

Caffeine History:

Yes ___No _____ if Yes Type?_____ Servings Per Day_____

Demographics:

The Federal Government requires us to collect the following information.
This information is part of the medical record and is subject to privacy laws.

Race (must choose one):

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

Ethnicity (check one) _____Hispanic _____Non-Hispanic
Primary Language Spoken:_____
Country of Birth (if not US): _____
Hand Dominance: _____Right _____Left _____Ambidextrous

Education:

Highest level of Education:_____
Any Degree obtained:_____

Employment:

Employer:_____
Occupation:_____
Employment Status:_____
If Retired, Date: _____

Military Experience:

No _____ Yes_____

Branch: _____

Years served: _____

Domestic:

Current Marital Status (circle one): Single Married Widowed Divorced

Previously widowed? ___ No ___ Yes

Previously divorced? ___ No ___ Yes

Children? ___ No ___ Yes # Sons____ # Daughters ____

Who lives with you? _____

Sleep Patterns:

Changes in sleep patterns: ___ No ___ Yes

Average number of hours of sleep per night: _____

Trouble falling asleep: ___ No ___ Yes

Difficulty staying asleep: ___ No ___ Yes

Frequent waking episodes at night: ___ No ___ Yes

Disrupted breathing, gasping, gagging or choking for air during sleep: ___ No ___ Yes

Lifestyle:

Activity level: ___Moderate ___Sedentary ___Vigorous

Health club member: ___Now ___Previously ___Never

Type of exercise: _____

Exercise frequency: _____

Hours/week: _____

Hobbies/Activities: _____

Current Diet : _____

Animals in the home: No__ Yes __ Type_____

Religious/Spiritual:

Do you have a religious affiliation? No ___ Yes ___ Religion name: _____

Home Environment/Safety:

Smoke detectors in home? No ___ Yes ___

Carbon monoxide detectors in home? No ___ Yes ___

Falls in the last year? No ___ Yes ___ Number of falls: ____

Pool/spa at home: No ___ Yes ___

Seat belt use? No ___ Yes ___

Recent Travel

Out of state? _____

Out of country? _____

Known exposure to disease? _____

Recreational Drug Use

_____ Yes _____ No _____ Formerly

Type	**How Often?**	**Route?**