PATIENT HISTORY QUESTIONNATIRE

NAME:			BIRTHDATE:		
WHA	AT ARE	E YOU HERE TO BE TREATED FOR	R AND	DATE	OF ONSET:
	CAL HIS		Цама	you had?	
Please Circle Appropriate Response:			Have you had?		
Please list medications and the dosages			NO	YES	Esophagogastroduodenoscopy (EGD) If yes, please list date and results
			NO	YES	Colonoscopy
					If yes, please list date and results
NO YES Are you allergic to any medications? Which ones? (please list allergy)			NO NO NO	YES YES YES YES	Blood pressure problems Abnormal x-rays, CT scans, or MRI's Asthma Tuberculosis
Please list all previous surgeries and dates:			NO NO NO NO	YES YES YES YES	Thyroid problems Heart trouble Diabetes Stomach problems
NO	YES		NO NO NO	YES YES YES	Excessive bruising or bleeding tendency Angina Epilepsy-convulsions or seizures
			NO NO	YES YES	Drug addictions Psychiatric consultation
Family Doctor:Phone			NO NO	YES YES	Kidney disease
Phone	;		NO	YES	Jaundice or hepatitis History of blood clots
NO	YES	Can we contact your primary care	NO	YES	Liver problems
110	120	physician's office?	NO	YES	Colitis
NO	YES	Have you ever received any anesthesia?	NO	YES	Cancer, If yes type
NO	YES	Have you ever had a reaction to anesthesia	? NO	YES	Smoke, If yes, how many packs for how many years?
NO	YES	Do you take any aspirin products or anti-			
NO	YES	inflammatory medicines? Do you take any blood thinners?			
NO	ILS	Which ones?			
Do an cancer		Family Members have colon or pancreatic			
If yes,	please li	st who and type			

___Date_____

Patient Signature_____