Jay A. Cherner, M.D.
Gastroenterology Consultants, P.C.
MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ AGE:____ DATE OF BIRTH:_____

OCCUPATION:_____ SEX:_____ TODAY'S DATE:_____

What problem caused you to consult a gastroenterologist? _____
_____
_____
_____
_____

Have you ever seen a gastroenterologist?_____ If yes, please complete below:

PHYSICIAN	PROBLEM	YEARS	CITY & STATE (if outside metro Atlanta)

Have you ever had a colonoscopy? _____ If yes, please complete below: (if polyps were removed, circle those years)

YEAR	PHYSICIAN	FACILITY	CITY & STATE (if outside metro Atlanta)

Have you ever had an upper endoscopy (EGD, gastroscopy)? _____ If yes, please complete below:

YEAR	PHYSICIAN	FACILITY	CITY & STATE (if outside metro Atlanta)

Please circle any of the tests you have had and provide approximate dates:

Barium Enema _____
C.T. Scan of abdomen _____
MRI of abdomen (or MRCP) _____
Ultrasound of abdomen (or gallbladder) _____
Upper G.I. series (using barium) _____
Capsule Camera _____
E.R.C.P. _____
Liver Biopsy _____
Sigmoidoscopy _____
P.E.T. Scan _____

Please list all previous surgeries (including approximate dates):_____
_____
_____

Other than for surgeries, have you ever stayed overnight in a hospital?_____ If so, please give the medical conditions that were treated and approximate dates:_____
_____

Have you visited an emergency room of a hospital or urgent care facility for any gastrointestinal problem in the past year? _____

List any **ALLERGIES TO MEDICINES:** _____
_____

List all **prescription medications** you are now taking (include doses). If you are not sure about name or dosage, please bring the medicine bottles with you to office consultation: _____
_____
_____

List all **non-prescription medications** you taken within the past two weeks or take on a frequent basis. Include aspirin (with dose), ibuprofen, Advil, Motrin, Alleve, naproxyn, vitamin E, laxatives, fiber supplements, suppositories, and enemas, antacids, Prilosec-OTC, Pepcid, Zantac, Tagamet Prevacid-OTC, Zegerid-OTC, probiotics._____
_____

Have you ever been diagnosed with cancer? _____ If yes, please provide primary organ involved and date first diagnosed:_____

Have you had a coronary angioplasty or stent placement?_____

Have you had a heart attack? _____

Have you been troubled by chest pain, chest pressure or smothering in past year? _____

Do you have atrial fibrillation? _____ Do you have any other abnormal heart rhythm? _____
Are you aware of any problems with the valves of your heart? _____

Do you take Coumadin?_____ If so, who prescribes it? _____

Do you take Plavix? _____ Do you take Aggrenox?_____

Do you have an implantable defibrillator? _____ Do you have a pacemaker? _____

Do you have difficulty breathing (asthma, COPD, emphysema)? _____ Do you use supplemental
oxygen?_____

Are there any problems with your kidney function (renal failure)? _____

Have you ever had a problem with a sedative or anesthesia? _____

Has anxiety been a major problem recently? _____

Do you smoke cigarettes? _____ How many per day? _____ For how many years? _____

If you no longer smoke, how much did you smoke, for how many years, and when did you stop? _____

Please circle the number of alcoholic beverages you typically consume in one week:

none 1 to 3 4 to 7 8 to 14 15 to 21 22 to 28 more than 28

If you no longer drink, how much did you drink, for how many years, and when did you stop?_____

Has either a parent, brother, sister, child or grandparent had cancer of colon or rectum?_____ If yes, what relationship and at what age was that person diagnosed? _____

Have parents or siblings had colon polyps? _____ Who? _____

Has either a parent, sibling or child had any of the problems listed below (indicate relationship)?

Breast cancer_____
Cirrhosis of liver_____
Crohn's disease_____
Kidney cancer_____
Ovarian cancer_____
Hemachromatosis_____
Hepatitis C _____
Pancreatic cancer_____
Sprue (celiac disease)_____
Stomach cancer_____
Ulcerative colitis_____
Uterus cancer_____
Hepatitis B _____

Please check any of the listed gastrointestinal problems that you have had. **Circle** those that are **active** at this time:

Anal Fissure (tear)_____
Anal itching or burning_____
Anal pain_____
Bleeding Hemorrhoids_____
Protruding Hemorrhoids_____
Rectal Bleeding_____

Frequent abdominal pain_____
Adhesions_____
Unintentional weight loss____
Bloating_____
Bowel Obstruction_____
Constipation_____
Diarrhea lasting more than 1 week_____
Diarrhea at least once per week_____
Fecal Incontinence (accidental BMs)_____
Seepage of stool_____
Filling up easily_____
Frequent nausea_____
Frequent or recent vomiting_____
Giardia or other parasites_____
Lactose intolerance_____
Oil in stool_____

Irritable Bowel Syndrome_____
Diverticulosis_____
Diverticulitis_____
Diverticular hemorrhage_____
Crohn's Disease_____
Ulcerative Colitis/Proctitis_____

Cirrhosis_____
Hemachromatosis_____
Hepatitis B_____
Hepatitis C_____
Fatty Liver_____
Jaundice_____
Pancreatitis_____
Other liver disorder (specify)_____

Acid reflux_____
Difficulty swallowing_____
Esophageal stricture_____
Esophagitis_____
Food hanging up in chest_____
Heartburn_____
Hiatal hernia_____
Regurgitation_____
Schatzki's Ring ____
Abdominal Hernia ____

My typical bowel pattern is:

(a) 1-2 per day_____
(b) 1 every other day_____
(c) 2-3 per week_____
(d) 1 per week_____
(e) 1 every 2 weeks_____
(f) 3 or more per day (give number)_____

Duodenal ulcer_____
Gastric ulcer_____
Peptic ulcer_____
Gallstones_____
Gallbladder surgery_____

Please circle those problems that have been present in the past year:

Fatigue
Weakness
Poor appetite
Unexplained fever
Night sweats
Malaise (just feel blah)
H.I.V.
Glaucoma
Double vision
Major vision loss
Hearing loss
Ringing in ears
Nasal congestion
Sinus problems
Diabetes
High thyroid
Low thyroid
Goiter
Tuberculosis
Bronchitis
Asthma
Emphysema
Chronic cough
Blood clot in lung
Coughing up blood
Shortness of breath
High blood pressure
Low blood pressure
Fainting
Chest pain
Angina
Congestive heart failure
Palpitations
Abnormal heart rhythm
Mitral valve prolapse
Rheumatic heart disease
Difficulty urinating
Burning when urinating
Awakening to urinate
Blood in urine
Kidney Failure
Kidney stones
Dialysis
Abdominal hernia
Anemia (low blood)
Low iron
Low platelets
Easy bleeding
Thalassemia
Blood clot in legs
Aneurysm of brain
Stroke
TIA (transient ischemic attack) ("mini stroke")
Continuous weakness of a limb
Continuous loss of sensation of a limb
Multiple sclerosis
Frequent headaches (non-migraine)
Migraine headaches
Cluster headaches
Muscle weakness
Seizures
Alzheimer's disease
Frequent numbness
Restless legs
Osteoarthritis
Rheumatoid arthritis
Other arthritis
Osteoporosis
Back pain
Neck pain
Fibromyalgia
Difficulty sleeping
Sleep apnea
Depression
Anxiety
Bipolar disorder
Hallucinations
Suicidal thoughts
Alcoholism
Drug dependence
IV drug use
Received transfusions
Donate blood more than once per year

WOMEN ONLY:
- Endometriosis
- Heavy menstrual periods
- Very painful menstrual periods
- Ovarian cysts
- Pain during intercourse
- Pelvic pain

MEN ONLY:
- Difficulty with erection
- Mass in testicles
- Pain in testicles
- Prostate cancer
- Prostate enlargement

If you think you have a significant medical problem that was not covered on this form, please list below:

_____

_____

_____