

**Silicon Valley Gastroenterology**  
**New Patient Questionnaire**

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Name:

Birthdate (00/00/0000):

Age:

Sex (circle):    M        F

Ethnicity:

Date of visit:

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Referring physician's name and address

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Name and address of other physicians that you would like information to be sent to

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What is the reason for this appointment? Please describe the symptoms that brought you to us.

### **Past Medical History**

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Have you ever been diagnosed with any of the following conditions? Please circle and comment as necessary

Esophageal problems or acid reflux (GERD)

Stomach problems

Liver disease or hepatitis

Colon polyps or cancer

Last colonoscopy (if any)

Irritable bowel syndrome (IBS)

Inflammatory bowel disease (IBD)

Heart disease

Blood clotting disorder

High cholesterol

Hypertension

Lung disease

Kidney or bladder disease

Alcohol or drug dependency

Cancer

Diabetes

Immune system disorder

Thyroid disease

Other medical problems (not listed above)

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### **Previous surgeries and hospitalizations**

**Current Medications** (Please list any medications (prescription or not, including vitamins and aspirin) that you are currently taking)

Medication	Dose	Number per day
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**Drug Allergies** (please list drugs and their adverse effects)

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**Social History**

Birthplace

Marital status

Highest level of education

Current occupation

Who lives at home with you?

Have you ever smoked cigarettes?

If yes, how many years?

Do you have any exposures to toxins or pesticides?

If you currently smoke, how much do you smoke per day?

Do you drink alcohol?

If yes, how much/often?

Do you exercise regularly?

If yes, how much/often?

Do you have any dietary restrictions?

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**Family Medical History**

Father

Mother

Siblings

Children

**Review of systems**

Have you experienced any of the following symptoms (please circle)

General	Poor general health
	Recent weight changes
	Fatigue
	Sleep difficulties
Immune system	Low resistance to infections
	Environmental allergies
Head & Neck	Hearing problems
	Chronic sinus problems
	Voice changes
	Frequent sore throat
	Changes in vision
Endocrine	Heat or cold intolerance
	Excess thirst or urination
Gastrointestinal	Changes in appetite
	Heartburn
	Acid regurgitation
	Difficulty swallowing
	Nausea
	Vomiting
	Abdominal pain
	Early fullness after meals
	Vomiting blood
	Black stools
	Rectal bleeding
	Diarrhea
	Constipation
Loss of bowel control	
Cardiovascular	Chest pain
	Irregular or fast heart rate
	Breathing difficulty
	Swelling of the feet

Respiratory	Chronic cough
	Coughing blood
	Wheezing
Genito-urinary	Blood in the urine
	Frequency or burning with urination
	Lack of bladder control
	Changes in sexual function
Hematologic	Easy bruising or bleeding
	Enlarged lymph glands
Musculoskeletal	Joint or muscle stiffness or pain
	Muscle weakness
	Back pain
	Difficulty walking
	Rashes
	Breast lumps
	Hair changes
Neurological	Frequent headaches
	Numbness
	Weakness
	Seizures
	Dizzy spells
	Memory problems
Psychiatric	Nervousness
	Depression
	Other
Gynecological	Last menstrual period
	Is it possible that you are pregnant?
	Last Pap smear
	Last mammogram