eGASTROMD
ERIC MORGENSTERN, MD, PLLC GASTROENTEROLOGY

Appointment Date_____

MEDICAL QUESTIONNAIRE

This medical questionnaire will assist us in understanding your medical status. Please answer all the questions fully, printing or writing legibly. If you are uncertain about a question or answer, use a question mark(?). Thank you for helping us help you.

Name:_____ Today's Date:_____

Date of birth:_____ Age:_____ SS#:_____

Home address: Street:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work:_____ Cell:_____

Email:_____

Problem or reason for your visit:_____

Referring physician:_____

Primary care physician ( ) same:_____

Insurance Name:_____ Primary Subscriber? ☐ Yes ☐ No

Contract #:_____ Group #:_____

Secondary Insurance Name:_____

Contract #:_____ Group #:_____

Do you have a living will? ☐ Yes ☐ No

Do you have power of attorney for health care decisions? ☐ Yes ☐ No

SOCIAL HISTORY *(check all that apply)*:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other

Employment/School/Occupation:_____

Stress Issues ☐ Work ☐ Recent Trauma ☐ Illness in Family ☐ Relationship Issues ☐ Family Issues

Comments: _____

Tobacco: ☐ Never ☐ Current ☐ Previously (year quit:_____)

☐ Cigarettes ☐ Chew Tobacco ☐ Cigars ☐ Amount:_____

Alcohol: ☐ None ☐ Beer ☐ Wine ☐ Liquor ☐ How often/How much:_____

Caffeine: ☐ None # cups/day:_____

Diet: Are you on a special diet? ☐ Diabetes ☐ Cardiac ☐ Celiac Sprue ☐ Lactose Free ☐ Other

Recreational Drugs: _____

Are you sexually active?: ☐ Yes ☐ No ☐ Not currently

If yes, is/are your partner(s)?: ☐ Male ☐ Female ☐ Both

Type of birth control/protection currently used:

☐ Not having sex (Abstinence) ☐ Condom ☐ Injection ☐ IUD (Intrauterine Device)

☐ Oral Contraceptives (Pill) ☐ Patch ☐ Post-menopausal ☐ None ☐ Other (specify): _____

MEDICATIONS - List all medications you presently take including aspirin, vitamins, calcium, laxatives, stool bulking agents, over-the-counter pills, eye drops, etc. Also list medications that you take occasionally. *(Attach additional pages if necessary)*

☐ N/A

Medicines	Dosage (if known)	If regular use how often/day	If occasional check here	Reason for use

NON-TRADITIONAL MEDICATIONS / THERAPIES - *(Attach additional pages if necessary)*

☐ N/A

Please list current herbs, dietary supplements or alternative therapies.

Medicines	Dosage (if known)	If regular use how often/day	If occasional check here	Reason for use

ALLERGIES - List all allergies to drugs, medicines, bee sting, etc. and give reaction. **Are you allergic to latex? ☐ Yes ☐ No**

Have you been advised to take antibiotics before medical or dental procedures? ☐ Y ☐ N

Are you allergic to Penicillin? ☐ Y ☐ N

Drug/Agent	Reaction	Drug/Agent	Reaction

PREVIOUS GI EVALUATIONS - Give the year, location (hospital or x-ray office) and, if known, result of the following medical studies:

☐ N/A

	Year(s)	Location	Result (circle "NL" if normal – "?" if unknown)
Colonoscopy			NL ?
Upper Endoscopy (EGD)			NL ?
Abdominal CAT (CT) Scan			NL ?
Abdominal Sonogram (Ultrasound)			NL ?
Barium Enema			NL ?
Upper GI Series			NL ?

PREVIOUS GI EVALUATIONS - Give the year, location (hospital or x-ray office) and, if known, result of the following medical studies:

☐ N/A

☐ Appendectomy
☐ Bariatric surgery
☐ Bowel resection
☐ Breast surgery
☐ Cholecystemctomy (gall bladder removal)
☐ Colonoscopy
☐ Other (specify)

☐ Cosmetic surgery
☐ C-Section
☐ Eye surgery
☐ Heart surgery
☐ Hepatobiliary surgery
☐ Hernia repair

☐ Hysterectomy
☐ Kidney transplant
☐ Liver transplant
☐ Orthopedic surgery
☐ Sterialization
☐ Vascular surgery

GASTROINTESTINAL HISTORY -

(Please check all that apply to you. Use blank space for additional information.)

☐ N/A

UPPER GI:

☐ Frequent mouth ulcers ☐ Stomach ulcers ☐ Weight loss #_____ ☐ Heartburn (GERD) ☐ Nausea
☐ Swallowing difficulty/food sticking ☐ Belching ☐ Weight gain ☐ Painful swallowing ☐ Black stools
☐ Vomiting

☐ N/A

LOWER GI:

☐ Bloating ☐ Excessive rectal gas/flatus ☐ Painful bowel movements ☐ Constipation ☐ Rectal bleeding
☐ Diarrhea ☐ Lower abdominal pain ☐ Colon cancer ☐ Loss of stool/ fecal accidents ☐ Family history of colon cancer: specify_____
☐ Colon Polyps ☐ Crohn's Disease ☐ Ulcerative Colitis
☐ Irritable Bowel Syndrome (IBS)

☐ N/A

DIGESTIVE ORGANS:

LIVER
☐ Yellow eyes (jaundice)
☐ Cirrhosis
☐ Hepatitis: explain_____
☐ Fatty Liver
☐ Liver transplant
☐ Hepatitis B vaccination
☐ History of blood transfusions

GALL BLADDER
☐ Gallstones
☐ Gallbladder surgery

PANCREAS
☐ Pancreatitis
☐ Pancreatic Cancer
☐ Pancreatic Cysts

FAMILY HISTORY - Please provide the following information on your parents, siblings and children.

☐ Adopted/Unknown Family History

(circle Male or Female)	Age if Living	Check (✔) if Healthy	Age at Death	Major Illness(es) and/ or cause of death	*(circle Male or Female)*	Age if Living	Check (✔) if Healthy	Age at Death	Major Illness(es) and/ or cause of death
Father					Child M F				
Mother					Child M F				
Sibling M F					Child M F				
Sibling M F					Child M F				
Sibling M F					Child M F				
Sibling M F					Child M F				

GASTROINTESTINAL FAMILY HISTORY* - *(check all that apply)*

☐ N/A

	Colon CA	Colon Polyps	Ulcerative Colitis	Crohn's	Irritable Bowel Syndrome	Liver Disease	Celiac Disease	Alcohol Abuse
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐
Brothers #_____	☐	☐	☐	☐	☐	☐	☐	☐
Sisters #_____	☐	☐	☐	☐	☐	☐	☐	☐
Sons #_____	☐	☐	☐	☐	☐	☐	☐	☐
Daughters #_____	☐	☐	☐	☐	☐	☐	☐	☐

*Please add any other important family health information:_____

_____

PAST MEDICAL HISTORY

Do you have a history of any of the following? *Check all that apply.*

CARDIOVASCULAR: ☐ N/A

- ☐ Murmur
- ☐ Pacemaker
- ☐ History of heart attack
- ☐ Angina
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ Coronary Heart Disease
- ☐ Implantable Defibrillator
- ☐ High cholesterol
- ☐ Anemia
- ☐ Anticoagulation Therapy
- ☐ Previously underwent a cardiac catherization
- ☐ Heart transplant
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Heart valve replacement

Specify:_____

LUNG: ☐ N/A

- ☐ Emphysema or Asthma
- ☐ Lung cancer
- ☐ Lung transplant
- ☐ Chronic cough

URINARY: ☐ N/A

- ☐ Bladder infection/UTI's
- ☐ Kidney disease:_____
- ☐ Dialysis: Hemodialysis ☐ Peritoneal ☐
- ☐ Kidney stones
- ☐ Kidney transplant
- ☐ Cancer of the kidney

ENDOCRINE: ☐ N/A

- ☐ Thyroid problem or goiter
- ☐ Diabetes
- ☐ Insulin

REPRODUCTIVE: (female) ☐ N/A

- ☐ Are you pregnant or planning a pregnancy
- ☐ Post-menopausal
- ☐ Sexually transmitted disease
- ☐ Vaginal delivery #_____
- ☐ Cancer of cervix, uterus, ovary, endometrium, breast: _____

REPRODUCTIVE: (male) ☐ N/A

- ☐ Prostate problem
- ☐ Sexually transmitted disease
- ☐ Impotence
- ☐ Prostate cancer; treatment_____

NERVOUS SYSTEM/PSYCHOSOCIAL: ☐ N/A

- ☐ Syncope
- ☐ Seizures / Epilepsy
- ☐ Chronic headaches (not migraine)
- ☐ Anxiety
- ☐ Migraine headaches
- ☐ History of stroke or TIA
- ☐ Insomnia
- ☐ Depression

SKIN: ☐ N/A

- ☐ Psoriasis
- ☐ Eczema
- ☐ Acne
- ☐ Skin cancer
- ☐ Melanoma

EYES: ☐ N/A

- ☐ Glasses / Contacts
- ☐ Glaucoma
- ☐ Cataracts

EARS: ☐ N/A

- ☐ Hearing aid

MUSCULAR/SKELETAL: ☐ N/A

- ☐ Arthritis
- ☐ Degenerative Joint Disease
- ☐ Osteopenia
- ☐ Osteoporosis

REVIEW OF SYSTEMS

Please check any current problems / symptoms you have experienced in the last 6 months.

CONSITUTIONAL: ☐ N/A

- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Excessive sweating
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected weight change

EARS, NOSE, MOUTH, THROAT AND FACE: ☐ N/A

- ☐ Hearing loss
- ☐ Dental problem
- ☐ Nosebleeds
- ☐ Mouth sores
- ☐ Postnasal drip
- ☐ Trouble swallowing

EYES: ☐ N/A

- ☐ Eye redness
- ☐ Visual disturbance

RESPIRATORY: ☐ N/A

- ☐ Stop breathing at night
- ☐ Shortness of breath or difficulty breathing
- ☐ Chest tightness
- ☐ Cough
- ☐ Choking
- ☐ Wheezing

CARDIOVASCULAR: ☐ N/A

- ☐ Chest Pain
- ☐ Leg swelling
- ☐ Palpitations (racing heart beats)

GENITOURINARY: ☐ N/A

- ☐ Difficulty urinating
- ☐ Enuresis (incontinence)
- ☐ Kidney stones
- ☐ Flank pain
- ☐ Dysuria (painful urination)
- ☐ Blood in urine

FEMALE PATIENTS ONLY: ☐ N/A

- ☐ Menstrual problem
- ☐ Vaginal bleeding
- ☐ Pelvic pain
- ☐ Nipple discharge
- ☐ Vaginal discharge
- ☐ Painful intercourse

MALE PATIENTS ONLY: ☐ N/A

- ☐ Penile discharge
- ☐ Hesitancy / dribbling
- ☐ Scrotal swelling
- ☐ Testicular pain

MUSCULOSKELETAL: ☐ N/A

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Gait problem
- ☐ Leg cramps

SKIN: ☐ N/A

- ☐ Color change
- ☐ Rash
- ☐ Wound

NEUROLOGIC: ☐ N/A

- ☐ Dizziness
- ☐ Numbness
- ☐ Tremors
- ☐ Headaches
- ☐ Speech difficulty
- ☐ Weakness
- ☐ Light-headedness
- ☐ Fainting
- ☐ Confusion

HEMATOLOGIC (blood): ☐ N/A

- ☐ Swollen lymph nodes
- ☐ Bleeds/bruises easily

BEHAVORIAL/PSYCHOLOGICAL: ☐ N/A

- ☐ Agitation
- ☐ Nervous / anxious
- ☐ Suicidal thoughts
- ☐ Behavior problem
- ☐ Self-injury
- ☐ Decreased concentration
- ☐ Sleep disturbance

REGISTRATION (PLEASE PRINT)

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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