ADC THE AUSTIN DIAGNOSTIC CLINIC Gastroenterology and Hepatology

PATIENT INTAKE QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Describe the reason for your visit today:_____

PRIMARY CARE AND REFERRING PROVIDER INFORMATION

Are your Primary Care Provider and the Referring Provider the same? _____ Yes _____ No

Primary Care Provider Name: _____ Primary Care Provider Phone: _____

Referring Provider Name: _____ Referring Provider Phone: _____

MEDICATIONS

Are you allergic to any medication? _____Yes _____ No

1. List any Drug Allergies:

Medication Name	Allergic Reaction

2. List all medications including over the counter and supplements

Medication Name	Dosage	How often

GENERAL HEALTH HISTORY

3. Do you have, or have you experienced? *Please check the box for only those that apply*

EENT	Now	Past	Gastrointestinal	Now	Past	Neurology	Now	Past
Glaucoma			*Colon Polyps*			Migraines/headache		
Cataracts			*Colon Cancer*			Dizziness/ Vertigo		
Conjunctivitis			Abdominal Pain			Head trauma/ Injury		
Eye Pain			Nausea / Vomiting			Fainting		
Blurred vision			Unintentional Weight Loss			Seizures		
Visual changes			Diarrhea			Stroke		
Nosebleeds			Constipation			Other:		
Sores in mouth			Blood in Stools			**Psychology**		
Hoarseness			Black Stools			Anxiety disorder		
Other:			Heartburn / Reflux			Depression		
Cardiovascular			Irritable bowel syndrome			Panic attacks		
High Blood Pressure			Crohn's Disease			Eating disorder		
Angina (chest pain)			Ulcerative Colitis			Other:		
Heart attack			Pancreatitis / Pancreas			**Hematology**		
Heart murmur			Peptic Ulcer Disease			Anemia		
Heart racing/skipping			Diverticulitis			Blood disorder		
Palpitations			Hepatitis A, B or C			Bleeding Problems		
Other:			Hiatal Hernia			HIV		
Respiratory/Lung			Lump in throat			Other:		
Chronic Cough			Difficulty swallowing			**Oncology**		
Shortness of Breath			Hemorrhoids			Breast Cancer		
Wheezing / Asthma			Bloating			Prostate Cancer		
Trouble breathing			Celiac Disease			Other:		
Other:			Liver Disease			**Endocrine**		
Genitourinary			Gallbladder Disease			Diabetes Mellitus		
Blood in Urine			Other:			Hyperthyroidism		
Burning/ Pain w. Urination			**Dermatology**			Hypothyroidism		
Recent / Freq UTI			Itching/Dry Skin			Osteoporosis		
Kidney Stones			Skin Rash			Osteopenia		
Other:			Jaundice: yellow eyes/skin			Thyroid – other		
Musculoskeletal			Other:			Other:		
Back pain			**Allergy**					
Loss of Balance			Seasonal Allergies			**Rheumatology**		
Joint Pain/Arthritis			Other:			Arthritis		
Problems walking						Joint Pain		

Decreased range of motion						Autoimmune disease (Lupus, RA)		
Leg pain						Other:		

If YES to any of the above, please clarify including dates:

_____

_____

4. Please list any previous hospitalizations, surgeries or procedures (i.e. Endoscopy, colonoscopy, surgical implants) and the dates

Procedure	Date

FAMILY HISTORY

5. Do you have any **Family history** of the following? *Please check the box for those that apply*

Diagnosis	Mother	Father	Children	Sister	Brother	Grf	Grm	Aunt	Uncle	Age of diagnosis
Deceased (age)										
Colon Cancer										
Colon Polyps										
Celiac Disease										
Ulcerative Colitis										
Chrohn's Disease										
Liver Disease										
Ovarian Cancer										
Uterine Cancer										
Kidney Cancer										
Stomach Cancer										
Esophagus Cancer										
Pancreatic Cancer										
Gallbladder Disease										
Hypertension										
Diabetes										
Heart Disease										
Stroke										
Autoimmune (Lupus, RA)										
Other Cancer:										

SOCIAL HISTORY

Marital Status: _____ Single ____ Married _____Divorced ____ Widow/Widower

Current Employer/Occupation: _____

	Yes	No	Frequency	If you quit, what year
Do you use tobacco products including smokeless or vaping?				
Do you drink alcohol?				
Do you use recreational drugs				