West Chester Gastrointestinal Group

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PATIENT QUESTIONNAIRE

LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX (JR, SR, III)
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL:
DATE OF BIRTH / AGE	SOCIAL SECURITY NUMBER	SEX	
MARITAL STATUS	SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	
NAMES AND AGES OF OTHERS LIVING WITH YOU:			
EMPLOYER	OCCUPATION		
REFERRING PHYSICIAN	FAMILY PHYSICIAN		
EMERGENCY CONTACT NAME:	PHONE NUMBER(S):		

HOW DID YOU HEAR ABOUT OUR OFFICE? (please check ALL that apply)

[ ] OUR WEBSITE	[ ] INTERNET SEARCH	[ ] CHESTER COUNTY HOSPITAL WEBSITE
[ ] NEWSPAPER ADVERTISEMENT	[ ] OTHER ADVERTISEMENT	[ ] RADIO
[ ] FROM A FRIEND/FAMILY	[ ] YELLOW PAGES	[ ] OTHER (PLEASE SPECIFY):

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU FOR EVERY VISIT.

Primary Insurance
Insurance Company Name:
Secondary Insurance
Insurance Company Name:

If your insurance requires referrals, it is your responsibility to contact your primary care physician's office staff to have these issued prior to your appointment. Some offices require 2 to 3 days notice, so do not wait until the last minute. IF YOU DO NOT HAVE A REFERRAL FOR YOUR VISIT, YOU MAY BE FINANCIALLY RESPONSIBLE OR BE REQUIRED TO RESCHEDULE YOUR APPOINTMENT. I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to be paid directly to West Chester G.I. Associates, P.C. and West Chester Endoscopy, L.L.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient Name (print) **Patient Signature** **Date**

FOR OFFICE USE ONLY:			
Demographics entered/verified:	DATE:	Physician Review:	DATE:

MEDICAL QUESTIONNAIRE

Reason You Were Referred and/or Major Digestive Complaint:

Past Medical History: Medical Illness						
1. Heart disease	Yes	No	7. Cancer	Yes	No	Type
2. Heart attack	Yes	No	8. Stroke or neurological disease	Yes	No	
3. High blood pressure	Yes	No	9. Blood disorder	Yes	No	
4. Diabetes	Yes	No	10. Other			
5. Lung disease	Yes	No	11. Other			
6. Kidney disease	Yes	No	12. Other			
Name of physician(s) treating any of the above:						

Past Surgical History – list operations and dates	
1.	4.
2.	5.
3.	6.

Prior Gastrointestinal or Liver Disease:					
1. Irritable bowel	Yes	No	3. Cirrhosis or hepatitis	Yes	No
2. Ulcer	Yes	No	4. Colon Cancer or Colon Polyps	Yes	No
5. Other:					
Have you ever seen a gastroenterologist?			Yes No		
Name and address:					

Prior Gastrointestinal X-rays/Colonoscopy/Endoscopy:		
1) What kind:	When:	Where:
Why:		
2) What kind:	When:	Where:
Why:		

Medications:		
1.	4.	7.
2.	5.	8.
3.	6.	9.

Allergies:
To Medications:
To Intravenous dye/iodine/shellfish/latex/eggs:

Patient Name (print) **Patient Signature** **Date**

Family Medical History:	
(G.I. illnesses, stomach, liver, colon or gallbladder)	
1.	3.
2.	4. Colon Cancer or Colon Polyps Yes No

Other Family Illnesses:	
1.	3.
2.	4.

Travel & Lifestyle:
Foreign Travel in the Past Year:
Transfusions:
Tobacco Usage: What type and how many:
Alcohol Usage: What type and how many:
Aspirin Usage; Other Arthritis Medicine:

Female Patients Only:	
Gynecologic history:	
Gynecologist:	Last Visit:
Last menstrual period (if applicable)	Present/prior birth control usage:

DO YOU NOW HAVE: (circle)
1. RESPIRATORY: Asthma, pneumonia, chronic bronchitis, TB, emphysema, wheezing, shortness of breath, cough.
2. CARDIOVASCULAR: Chest pain, heart attack, valve replacement, palpitations, irregular rhythm, leg swelling.
3. SKIN: Itching, rashes.
4. BLOOD: Anemia, bleeding problems, swollen lymph glands, easy bruising.
5. GENITOURINARY: Bladder or kidney infection, kidney stones, frequent urination, burning, incontinence (leakage), blood in urine, difficulty urinating. Women: Menstrual irregularities, heavy bleeding, pain.
6. EMOTIONAL: Depression, crying spells, nervousness, trouble sleeping, excessive stress.
7. BONES (JOINTS): Swelling, arthritis, muscle cramps, joint pain, back pain.
8. HEAD: Vision change (besides glasses or contacts), inflammation of eyes, sinusitis, nosebleeds, hoarseness, severe gum or dental disease, sore tongue, throat pain.
9. ALLERGIC: Hay fever, eczema, food allergies/sensitivities.
10. NEUROLOGICAL: Seizures, headaches or migraine, stroke, numbness/tingling, dizziness.
11. ENDOCRINE: Diabetes, thyroid disease.
12. CONSTITUTIONAL: Weight loss or gain, fever, chills, night sweats, fatigue, weakness.
13. GASTROINTESTINAL: Loss of appetite, excessive belching or flatus (gas), nausea, vomiting, regurgitation, heartburn, trouble or pain with swallowing, abdominal pain, diarrhea, constipation, change in bowel habits, rectal bleeding, vomiting blood, bloating, use of laxatives, jaundice.