Staple

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CLINICS DIGESTIVE HEALTH NEW PATIENT QUESTIONNAIRE

Date: _____

Referring MD (Name, Address, Phone Number):	*Primary Care Physician (Name and Address, Phone Number):*

Reason for visit: _____

1. How long have you had symptoms? _____

   Describe your symptoms? _____

2. Have your symptoms affected your ability to carry out your daily activities? ❑ YES ❑ NO

3. What diagnosis (if any) have you been given? _____

If you have changes in your bowel patterns, please fill out the section below. If you have had no changes, please skip to #4.

BOWEL HABITS:

Have you recently had:

Changes in gas	❑ YES	❑ NO	
Blood in your stools	❑ YES	❑ NO	
Blood after bowel movements (in toilet/ on paper)	❑ YES	❑ NO	
Black tarry stools	❑ YES	❑ NO	
Sticky bowel movements	❑ YES	❑ NO	
Urgency	❑ YES	❑ NO	
Pain ***JUST BEFORE, DURING,*** or ***AFTER*** bowel movements	❑ BEFORE	❑ DURING	❑ AFTER
Nocturnal BMs (do BMs wake you out of your sleep)	❑ YES	❑ NO	

# of bowel movements per day: _____

Consistency of bowel movements: ❑ Watery ❑ Soft ❑ Normal ❑ Hard Pellets

4. Other Medical Problems (past and present):

PAST	PRESENT

5. Prior Surgeries and Hospitalizations (include month, year, location):

6. Current Medications: (include non-prescription and supplements):

PAST		PRESENT	
Medication & Dosage	Frequency	Medication & Dosage	Frequency

7. Prior Treatment for Current Problem:

PAST	PRESENT

8. Medication allergies: _____

9. Cigarette smoking? ❑ YES ❑ NO
   If yes, how much and how long: _____

10. How much alcohol do you drink? _____
    Other drugs _____
    Marijuana? ❑ YES ❑ NO

11. Family History (Please check and indicate family member, if appropriate)

FAMILY HISTORY	FAMILY MEMBER
❑ Crohn's Disease or Ulcerative Colitis	
❑ Celiac Sprue	
❑ Autoimmune Disorder? Lupus, Scleroderma, Arthritis	
❑ Liver Disease	
❑ Colon Cancer/ Polyps	
❑ Other Cancers	
❑ Diabetes	
❑ Obesity	
❑ Depression/ Anxiety/ Substance Abuse	
❑ Other:	
❑ None of the above	

12. Do you feel depressed or anxious? ❑ YES ❑ NO

13. Have you ever experienced violence or abuse in your life? ❑ YES ❑ NO

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14. Please check Yes or No if you have had any of the following symptoms in the ***past 3 months***

System	Symptoms	Yes	No	Comments
General	Fevers/Chills/Sweats	❑ YES	❑ NO	
	Insomnia	❑ YES	❑ NO	
	Appetite Change	❑ YES	❑ NO	
	Weight Loss (past year)	❑ YES	❑ NO	
	Minimum weight #_____	❑ YES	❑ NO	
Dermatologic	Rashes	❑ YES	❑ NO	
	Nail Changes	❑ YES	❑ NO	
Head and Neck	Dry eyes	❑ YES	❑ NO	
	Ringing in the ears	❑ YES	❑ NO	
	Sore throat	❑ YES	❑ NO	
	Hoarseness	❑ YES	❑ NO	
	Mouth Sores	❑ YES	❑ NO	
Cardiac	Chest Pain	❑ YES	❑ NO	
	Palpitations	❑ YES	❑ NO	
Respiratory	Difficulty breathing	❑ YES	❑ NO	
	Coughing	❑ YES	❑ NO	
	Wheezing	❑ YES	❑ NO	
Genital/Urinary	Burning with urination	❑ YES	❑ NO	
	Blood in urine	❑ YES	❑ NO	
	Urinary incontinence	❑ YES	❑ NO	
	Genital sores	❑ YES	❑ NO	
Gastrointestinal	Blood in stools	❑ YES	❑ NO	
	Fecal incontinence	❑ YES	❑ NO	
	Difficulty swallowing	❑ YES	❑ NO	
	Heartburn	❑ YES	❑ NO	
	Nausea	❑ YES	❑ NO	
	Vomiting	❑ YES	❑ NO	
	Constipation	❑ YES	❑ NO	
	Abdominal pain	❑ YES	❑ NO	
Musculoskeletal	Chronic back pain	❑ YES	❑ NO	
	Swelling in hands or feet	❑ YES	❑ NO	
Neurologic	Headaches	❑ YES	❑ NO	
	Blurred vision	❑ YES	❑ NO	
	Numbness	❑ YES	❑ NO	
Hematology	Bruising	❑ YES	❑ NO	
	Prolonged bleeding	❑ YES	❑ NO	
	Anemia	❑ YES	❑ NO	

15. Please describe any problems with anesthesia or sedation for previous surgeries/ procedures?

_____

_____

_____

_____ _____ _____ _____

Date Time Signature (Patient or Properly Designated Representative) Print Name

_____

Relationship to Patient

_____ _____ _____ _____

Date Time Physician Signature/Title Print Name

If this document was translated:

_____ or _____ _____ _____ _____

Signature of Translator Name of Language Line Date Time Language