



Gastrointestinal
Specialists, PC

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____

Please fill out the following information as accurately as possible. If you need assistance, we will be happy to help.

- Reason of today's visit _____
- System Review. We need to know what symptoms you are experiencing. Please circle the correct responses.

A. CONSTITUTIONAL SYMPTOMS

Headache	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue/Tired	No	Yes
Night Sweats	No	Yes

B. CARDIOVASCULAR

Heart trouble	No	Yes
Chest Pain	No	Yes
Chest tightness	No	Yes
Pain in legs	No	Yes
Shortness of Breath	No	Yes
With walking	No	Yes
Lying flat	No	Yes
Swelling of feet	No	Yes
Swelling of hands	No	Yes
Palpitations (racing)	No	Yes
High Blood Pressure	No	Yes

C. RESPIRATORY

Chronic cough	No	Yes
Frequent cough	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes

D. GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel habits	No	Yes
Nausea/vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movement	No	Yes
Frequent constipation	No	Yes
Blood in stool	No	Yes
Abdominal pain	No	Yes
Heartburn	No	Yes
Peptic ulcer	No	Yes
Excess gas, bloating	No	Yes
Trouble swallowing	No	Yes

E. PSYCHIATRIC

Memory loss/confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

F. MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness	No	Yes
Weakness of muscles	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes
Arthritis	No	Yes

G. INTEGUMENTARY

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair/nails	No	Yes
Varicose veins	No	Yes

H. NEUROLOGICAL

Dizziness	No	Yes
Fainting spells	No	Yes
Blurred/cloudy vision	No	Yes
Convulsion/seizures	No	Yes
Numbness/tingling	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes

I. HEMATOLOGIC/LYMPATHIC

Easy bruising	No	Yes
Slow to heal	No	Yes
Easy to bleed	No	Yes
Anemia (low blood count)	No	Yes
Past blood transfusion	No	Yes

J. GENITOURINARY

Frequent urination	No	Yes
Burning urination	No	Yes
Blood in urine	No	Yes
Can't control bladder	No	Yes
Can't control bowels	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes

K. DISEASES

Hepatitis _____	No	Yes
Diabetes _____	No	Yes
Cancer _____	No	Yes
Lung Disease _____	No	Yes