NYU Department of Medicine
Division of Gastroenterology

New Patient Questionnaire

Name: __________________________ **Date:** ____/____/____

Date of Birth: ____/____/____ **Age:** ____

PAST MEDICAL HISTORY:

Have you had any of the following ? Please check if YES:

- ☐ Anemia
- ☐ Arthritis
- ☐ Ascites (fluid in the abdomen)
- ☐ Asthma or emphysema
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Blood clot in legs
- ☐ Cancer [type: ____________________]
- ☐ Chest pain / angina
- ☐ Colon polyps
- ☐ Depression
- ☐ Diabetes [if yes; year diagnosed ? _____]
- ☐ Epilepsy or seizures
- ☐ Heart Attack
- ☐ Heart Disease (including heart murmurs)
- ☐ Hepatitis A, B, or C (if yes, list treatments)
- ☐ High blood pressure [if yes, year diagnosed ? ____]
- ☐ High cholesterol
- ☐ Intestinal or rectal bleeding
- ☐ Jaundice (turning yellow)
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Lung disease
- ☐ Rheumatic or autoimmune disease
- ☐ Stroke / TIA [if yes, what year diagnosed ? ____]
- ☐ Thyroid problems
- ☐ Tuberculosis or a positive TB skin test
- ☐ Vascular disease (pain in legs with walking?)

Other Medical Problems / Details:

____

____

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____

____

Surgeries (incl endoscopies) & Date

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____

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____

____

Name: **DOB:** **Date:**

TESTING:

Have you ever had any of the following tests ? Please check if YES:

- □ Cardiac Stress Test When ? ____
- □ Colonoscopy / Upper Endoscopy When ? ____
- □ CT scan of the abdomen When? ____
- □ Echocardiogram When ? ____
- □ Liver Biopsy When ? ____
- □ Ultrasound of the liver When ? ____

Check if you have been vaccinated for:

- □ Hepatitis A
- □ Pneumovax (pneumonia)
- □ Hepatitis B
- □ Flu shot (for this season)

VITALS:

Weight: Currently ____ pounds Lowest weight: ____ pounds Highest weight: ____

MEDICATIONS:

Please list all the medications you are currently taking, including over the counters (TUMS, vitamins, Advil, aspirin, herbals, etc…)

ALLERGIES:

Please list all your allergies, including allergies to medications:

WOMEN only:

How many times have you been pregnant ? ______ # of children _____

Date of last menstrual period ? ____ / _____ / _____

Are you using birth control pills ? _____

Name: **DOB:** **Date:**

SOCIAL HISTORY:

Marital status: __ Single __ Married __ Divorced __ Widowed

Employment status: __ Retired __ Employed __ Homemaker __ Student __ Unemployed

On Disability: __ Yes __ No If yes, for what ? ________________________

Current Occupation: ______________________ Previous Occupation: _________________

Who lives with you ? ___________________

Number of children: _______ Ages: ___________________________

Highest grade of education: __ th grade __ Jr College __ College __ Graduate school

SUBSTANCE USE:

Substance	**Ever Used?**	**Current Use?**	**Amount per day / week**	**# years used**	**If Stopped, When?**
Caffeine (coffee, tea, soda):	Y N	Y N			
Tobacco	Y N	Y N			
Street drugs	Y N	Y N			
Injected drugs	Y N	Y N			
Alcohol	Y N	Y N			

Do you have any dietary restrictions ? if yes, what do you restrict ?

Do you exercise regular Y N ; if yes, what type of exercise and how often

Do you have tattoos? Y N If yes; professionally done ? Y N When ?

Name: **DOB:** **Date:**

FAMILY HISTORY:

Family Member	**Age** (if living)	**Health / Illnesses**	**Age at death & Cause**
Father			
Mother			
Sister / Brother			
Sister / Brother			
Sister / Brother			
Sister / Brother			
Sister / Brother			
Sister / Brother			
Son / Daughter			
Son / Daughter			
Son / Daughter			
Son / Daughter			
Mother’s Mother			
Mother’s Father			
Father’s Father			
Father’s Father			

Has any blood relative had any of the following ? If so, please provide relationship;:

- ◻ Cancer
  - Breast:
  - Colon:
  - Ovary / Uterus:
  - Pancreas
  - Other:

- ◻ Colon polyps
- ◻ Ulcer (duodenal or gastric)
- ◻ Ulcerative Colitis
- ◻ Crohn’s disease
- ◻ Irritable Bowel Syndrome
- ◻ Gallstones
- ◻ Liver Disease

Name: **DOB:** **Date:**

REVIEW OF SYSTEMS:

Do you CURRENTLY suffer from any of the following ? Please check if YES:

General:
- □ Poor appetite
- □ Easy fatigability
- □ Weight loss
- □ Itching / Rash
- □ Weight gain
- □ Anxiety
- □ Depression

Head:
- □ Eye trouble
- □ Vision changes
- □ Yellow eyes
- □ Hearing disorder
- □ Sore tongue or mouth

Neck:
- □ Goiter
- □ Lumps or masses
- □ Sore throat / hoarseness

Chest:
- □ Chest pain
- □ Asthma
- □ Shortness of breath
- □ Chronic cough
- □ Palpitations

GI:
- □ Abdominal pain
- □ Abdominal swelling
- □ Constipation
- □ Dark, tarry stool
- □ Heartburn / indigestion
- □ Milk intolerance
- □ Passing blood with stool
- □ Persistent nausea
- □ Swallowing difficulty
- □ Vomiting
- □ Vomiting blood

GU:
- □ Difficulty urinating
- □ Blood in urine
- □ Frequent urination
- □ Kidney stones

Extremities:
- □ Arthritis
- □ Swollen legs
- □ Joint aches
- □ Joint swelling
- □ Cold sensitivity

Neurologic:
- □ Headaches
- □ Memory loss
- □ Muscle weakness
- □ Numbness
- □ Confusion
- □ Trouble sleeping

Other:
- □ Anemia
- □ Iron deficiency
- □ B12 deficiency

EXPLAIN:

Anything else we should know about your health ?

I certify that the information provided in this document is correct. I understand that any omission of information or providing information in error may affect the NYU physician's assessment and recommendation:

_______________________________________ ____ / ____ / ____

Patient signature