Interventional Endoscopy Services (IES)

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Sutter Health CPMC We Plus You

Patient Questionnaire

Date: _____

Name: _____ Birth date: _____ Age: _____ ❑ Male ❑ Female

Preferred Phone: (___) _____ Other Phone: (____) _____ **Email:** _____

I, (**print patient's name**) _____ (or guardian of), hereby authorize the following physician (s) and/or institution (s) to release information obtained during the course of my diagnosis and treatment to California Pacific Medical Center and the Interventional Endoscopy Services, 2351 Clay Street., Suite #600; San Francisco, CA 94115. Further, I hereby authorize California Pacific Medical Center and the Interventional Endoscopy Services providers to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand that this agreement will be in effect until I revoke it in writing. A photocopy of these authorizations shall be valid as the original.

Referring Physician's Name: _____

*Address: _____City_____State_____Zip_____

*Phone Number:_____ *Fax Number:_____

Primary Care Physician's Name: _____

*Address: _____City_____State_____Zip_____

*Phone Number:_____ *Fax Number:_____

Do any of the following apply to you? ❑ None

❑ Pacemaker/type and model number (last date of interrogation) _____ ❑ Defibrillator/type and model number (last date of interrogation) _____ ❑ Home oxygen ❑ Kidney dialysis

BLOOD THINNERS (such as Xarelto, Pradaxa, Eliquis, Coumadin, Lovenox, Plavix, Aggrenox) date of last dose taken_____ If yes, cardiologist name and number _____

WHAT IS YOUR MAIN COMPLAINT? _____

_____

_____

SYSTEMS REVIEW Do you experience any of the following? ❑ None

❑ Weight loss	❑ Fever/chills	❑ Fatigue	❑ Abdominal pain
❑ Bloating	❑ Diarrhea	❑ Constipation	❑ Nausea ❑ Vomiting
❑ Blood in stool	❑ Heartburn	❑ Chest pain	❑ Difficulty swallowing
❑ Itching	❑ Loss of appetitie	❑ Easy bleeding	❑ Shortness of breath
❑ Blood in urine	❑ Painful bowels	❑ Yellow eye/skin	❑ Palpatations
❑ Fainting	❑ Hemorrhoids	❑ Changes in bowel habits	

Provide details/list other symptoms: _____

_____

PAST MEDICAL HISTORY Have you had any of the following diseases? ❑ None

❑ Diabetes	❑ Stroke	❑ Seizures	❑ Blood clots
❑ Ulcers	❑ Asthma	❑ Heart attack	❑ Heart failure
❑ GI Bleeding	❑ Hepatitis A, B or C	❑ High blood pressure	❑ Bleeding disorder
❑ Cancer (specify: _____)		❑ Kidney disease	❑ Anemia
❑ Atrial Fibrillation	**Provide details/list other diseases**: _____		

 PATIENT NAME: _____

PAST SURGICAL HISTORY What operations have you had? ❑ None

❑ Gallbladder	Date: _____YEAR:____	❑ Colon	Date: _____ YEAR:____
❑ Pancreas	Date: _____YEAR: ____	❑ Stomach	Date: _____ YEAR:____
❑ Appendix	Date: _____ YEAR:____	❑ Fundoplication	Date: _____ YEAR:____
❑ Hernia	Date: _____ YEAR:____	❑ Hysterectomy	Date: _____ YEAR:____
❑ Heart bypass	Date: _____ YEAR:____	❑ Transplantation	Date: _____ YEAR:____
❑ Heart/Artery stent			

Other: _____

PAST ENDOSCOPIC HISTORY What prior endoscopies have you had? ❑ None

❑ Upper endoscopy	Date: _____	Results? _____
❑ Colonoscopy	Date: _____	Results? _____
❑ ERCP	Date: _____	Results? _____

FAMILY MEDICAL HISTORY Which diseases run in your family? ❑ None

Cancers: ❑Esophagus ❑Stomach ❑Pancreas ❑Colon ❑Liver ❑Breast

Which relative?_____ Age at diagnosis?_____

Other diseases: ❑ Ulcers ❑Pancreatitis ❑Polyps ❑Colitis ❑Diabetes ❑Bleeding tendency

List any other family illnesses: _____

_____

MEDICATIONS Which medications are you taking? Please include: Dosage and how many times a day ❑None

❑Insulin	❑Oral anti-diabetic	❑Aspirin(dose) : _____		
❑Steroids	❑Non-steroidal	❑Antacids	❑H2 Blocker	❑Proton pump inhibtor
❑ Antibiotic	❑ Antidepressant	❑ Iron	❑Pain pills	❑Birth control pill

Please list all other medication: _____

_____

DRUG ALLERGIES Have you had an allergic reaction to any medication? ❑ No Known Drug Allergies

❑ Benzodiazepams ❑ Demerol ❑Antibiotics (specify) ❑Contrast agent

List any other drug allergies_____

SOCIAL HISTORY

Marital status: ❑ Single ❑Married ❑Widowed ❑Divorced

Number of Children: _____ Ages: _____

❑ Occupation (current or previous) _____ ❑Retired ❑Disabled

Tobacco: ❑ Never smoked ❑ Quit smoking/date _____ ❑ Still smoking

❑< 1 PPD ❑> 1 PPD No. of years smoked?____

Alcohol: ❑ None ❑ Beer ❑ Wine ❑ Mixed drinks

❑<1 drink/day ❑1-2 drinks/day ❑ ≥2 drinks/day

Recreational: ❑ marijuana ❑ heroin ❑ cocaine ❑ amphetamines

Others:_____

PLEASE BRING YOUR COMPLETED QUESTIONNAIRE WITH YOU TO YOUR APPOINTMENT