

Monterey Bay G.I. Consultants Medical Group, Inc.

Monterey Bay Endoscopy Center

NEW PATIENT QUESTIONNAIRE

(To be filled out at first visit or if patient not seen in over 1 year)

Patient Name: _____ Date: _____

Age of Patient: _____

Primary Care MD: _____

Referring MD: _____

Allergies: _____

Medications: _____

(Please list all or attach a list of your current medications)

Past Medical History: _____

Heart Disease Yes / No

Diabetes Yes / No

Asthma Yes / No

Sleep Apnea Yes / No

Arthritis Yes / No

Atrial Fibrillation Yes / No

Hypertension Yes / No

Other: _____ Yes / No

Past Surgical History: _____

Tobacco Yes / No

Alcohol Yes / No

If yes, number of drinks per day: _____

Family History:

Colon Cancer Yes / No

Polyps Yes / No

REVIEW OF SYSTEMS:

(Please circle yes or no)

Headaches Yes / No

Blurry Vision Yes / No

Chest Pain Yes / No

Cough Yes / No

Shortness of Breath Yes / No

Pain on Urination Yes / No

Rash Yes / No

Joint Pain Yes / No

Depression Yes / No

Fever or Chills Yes / No

Excessive Urination Yes / No

or Thirst Yes / No