

**ASHOK K. NARANG, M.D., P.A.**  
**GASTROENTEROLOGY & LIVER DISEASES**

**PATIENT QUESTIONNAIRE**

These forms will give an overview of your medical history and general health. Your doctor will review this with you at the time of your examination. Please **COMPLETELY FILL-OUT** the front and back of each page.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Referred by: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

**PAST HISTORY:**

Medical illness (High Blood Pressure, Diabetes, Heart, Lung, Kidney or Liver problems, Stroke, Seizures, Arthritis, Cancer, Emotional problems, etc.)

TYPE

APPROXIMATE DATE

<u>TYPE</u>	<u>APPROXIMATE DATE</u>

**SURGERIES:**

TYPE/YEAR  
(Approximate)

TYPE/YEAR  
(Approximate)

TYPE/YEAR (Approximate)	TYPE/YEAR (Approximate)

**MEDICATIONS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ARE YOU ALLERGIC TO ANY MEDICATIONS:** \_\_\_\_\_

\_\_\_\_\_

**ARE YOU ALLERGIC TO LATEX:** \_\_\_\_\_

**FAMILY HISTORY:**

Age (if living)

Age (if deceased)

Cause of death

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_

**Are these illnesses in your family:**

Please either  Yes or No for EACH illness.

Yes

No

If yes which family member(s), self included

Diabetes   \_\_\_\_\_

Hypertension   \_\_\_\_\_

Stroke   \_\_\_\_\_

Heart Attack   \_\_\_\_\_

Liver Disease   \_\_\_\_\_

Cancer Colon   \_\_\_\_\_

Breast   \_\_\_\_\_

Prostate   \_\_\_\_\_

Colitis, Colon Polyp   \_\_\_\_\_

Other \_\_\_\_\_

**SOCIAL HISTORY:**

Yes

No

AMOUNT

Tobacco Use   \_\_\_\_\_

Alcohol Use   \_\_\_\_\_

Caffeine Use   \_\_\_\_\_

Drug Use   \_\_\_\_\_

Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_

Education (Highest Year or Degree Obtained) \_\_\_\_\_

Hobbies/Interests \_\_\_\_\_

**DIETARY HISTORY:**

Food intolerance \_\_\_\_\_

Amount of following food consumed per day:

Milk \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Sodas \_\_\_\_\_

Other dairy products \_\_\_\_\_

**REVIEW OF SYSTEMS:** Circle any/all symptoms or problems which apply to you. If there are any terms that are not clear, please ask the doctor to explain at the time of your exam.

**COMMENTS**

Please indicate NONE if no symptoms

- 1) General Health: Maximum Weight\_\_\_\_; Lowest Weight\_\_\_\_; Fatigue; Loss of Appetite; Recent Weight Change; Anemia; Fever; Chills; Night Sweats \_\_\_\_\_  
\_\_\_\_\_
- 2) HEENT: Head Injury; Nose Bleeds; Recurrent Sinus Infections; Seasonal Allergies; Glaucoma; Cataracts; Unusual Visual Disturbances; Ringing in Ears; Dizziness; Swallowing Disorder; Hoarseness; Gum Disease; Mouth Sores \_\_\_\_\_  
\_\_\_\_\_
- 3) Pulmonary: Pneumonia; Asthma; Tuberculosis; Chronic Cough; Coughing up Blood; Positive TB Skin Test or TB Exposure; Shortness of Breath (Date of Last Chest X-ray\_\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_
- 4) Cardiac: History of Rheumatic Fever; Murmur; Chest Pain; Swelling of Legs; Irregular or Skipped Heart Beats \_\_\_\_\_  
\_\_\_\_\_
- 5) Vascular: History of Hypertension (High Blood Pressure); Leg Pains when walking; Clots; Aneurysm \_\_\_\_\_  
\_\_\_\_\_
- 6) Gastrointestinal: Indigestion; Hiatal Hernia; Peptic Ulcer Disease; Hepatitis; Gallbladder Disease; Pancreatitis; Diarrhea; Constipation; Rectal Bleeding; Recurrent Nausea or Vomiting; Food Intolerance; Swallowing Pain \_\_\_\_\_  
\_\_\_\_\_
- 7) Genitourinary: Recurrent Bladder or Kidney Infections; Kidney Stones; Prostate Disorder; Incontinence; Frequent Urination; Urination at Night \_\_\_\_\_  
\_\_\_\_\_

