KU WICHITA GASTROENTEROLOGY
The University of Kansas

PATIENT INFORMATION FORM

NAME_____ DOB_____ TODAY'S DATE_____

Primary Care Physician_____ Referring Provider_____

Why are you here today? _____

LIST YOUR Medical Problems and Surgical History:

_____

_____

_____

Date of Previous Colonoscopy _____ Polyps removed Yes___ No ___ If yes, how many? _____

Date previous EGD (stomach scope) _____

Medications:_____

_____

Allergies:_____

_____

Family Health Problems:

Grandparents	
Father	
Mother	
Brother/Sister	
Son/Daughter	

Please list all family members and age at diagnosis of colon, endometrial, breast, ovarian, uterine, stomach, esophageal, pancreatic or liver Cancer:

_____

_____

_____

Please list all family members who have been diagnosed with Crohns, Ulcerative Colitis, Celiac disease, Hepatitis B and Hepatitis C:

_____

Circle One: Single Married Separated Divorced Widowed

Sexual Partner Preference: Male Female Both

Have you been sexually active within the last month: ___ No ___ Yes

Have you ever used any of the following: ___ Marijuana ___ Cocaine ___ Speed ___ Other IV Drugs

Alcoholic Beverages: ___ Amount ___ Drinks per Week ___ History? ___ How Much ___How Long

Cigarettes/Cigar/Pipe/Vape (E-Cigarettes): ___ Amount ___ Packs Per Day ___ Don't Smoke __Quit Date

Hepatitis Risk Factors (circle Yes or No):

History of tattoos?	YES	NO
History of Blood Transfusions?	YES	NO
Ever been in Prison?	YES	NO
Ever snorted cocaine?	YES	NO
Born between 1945-1965?	YES	NO
History of Hemodialysis?	YES	NO
Received clotting factors prior to 1987?	YES	NO
History of organ transplant prior to 1992?	YES	NO
Have you ever been screened for Hepatitis A, B or C?	YES	NO
Ever been in Military?	YES	NO
History of needle stick or blood exposure?	YES	NO
If you answered yes to any of the above questions, would you like to be screened for Hepatitis B and C?	YES	NO

Circle any of the following conditions that you have a history of:

Skin
Rash
Itching
Lumps

Endocrine
Excessive Sweating
Excessive thirst
Excessive Urination
Heat intolerance
Cold intolerance

Eyes
Blurred Vision
Diminished or Vision Loss
Painful or irritated eyes

Psychology
Depression
Anxiety
Sleep Disturbance
Eating disorder

Hematology
Easy bruising
Swollen glands
Fatigue
Anemia

General
Weight Loss
Weight gain
Loss of appetite
Fever
Weakness

Cardiology
Shortness of breath
Chest pain
Dizziness
Lower extremity swelling

Gastroenterology
Nausea
Vomiting
Heartburn
Trouble Swallowing
Abdominal pain
Diarrhea
Change in bowel habits
Constipation
Black stools
Blood in stools

Muscoskeletal
Joint pain
Stiffness
Leg cramps
Neck pain
Metal in body