Patient name _____
Date _____

Center for Digestive Health

Inflammatory bowel disease medical exam questionnaire

Patient information

Name _____ Date of birth ____ / ____ / ____ Age _____

Marital status _____ Race _____ Height _____

Present weight _____

Usual weight _____

Desired weight _____

Insurance ____ Yes ____ No

Manage care ____ Yes ____ No

Self-referral ____ Yes ____ No

Primary care physician

Name _____

Address _____

_____

City _____

Phone (____) _____

Fax (____) _____

Referring physician (if different from PCP)

Name _____

Address _____

_____

City _____

Phone (____) _____

Fax (____) _____

VCU Medical Center
Virginia Commonwealth University
Every Day, A New Discovery.®

Patient name _____

Medical history

1. How would you rate your present health?

   _____ Excellent _____ Good _____ Fair _____ Poor

2. What type of inflammatory bowel disease have you been diagnosed with?

   _____ Crohn's disease _____ Ulcerative colitis

   _____ Colitis indeterminate _____ Collangenous colitis

   _____ Miscopic/lymphocytic colitis _____ Other

3. Have you ever had an operation for inflammatory bowel disease?

   _____ Yes _____ No

4. Have you ever had pouchitis?

   _____ Yes _____ No _____ Don't know

5. Do you have any fistulas communicating from the GI tract to the skin or some other area of the body?

   _____ Yes _____ No _____ Don't know

6. Have you ever been on steroids?

   _____ Yes _____ No

7. Have you ever taken immunosuppressive medications, such as 6-MP, Imuran, methotrexate, cyclosporine or Remicade?

   _____ Yes _____ No

   Which one(s)? _____

   _____

8. Have you ever had a bone densitometry test?

   _____ Yes _____ No

   If yes, when? _____

9. When was the last time that you had an eye examination?

   _____

10. When was the last time you saw your dentist?

    _____

Patient name _____

Medical history, continued

Have you ever had or done any of the following?	Yes	No	Don't know
Rheumatic fever			
Received a blood transfusion			
Used intravenous drugs			
Tested for Hepatitis A			
Tested for Hepatitis B			
Tested for Hepatitis C			
Tested for HIV			

If you have allergies to medications, list the drug and reaction.

_____

_____

_____

_____

Have you received any of the following immunizations?	Yes	No	Don't know	What year?
Hepatitis A				
Hepatitis B				
Tetanus				
Pneumovax				
Annual flu vaccine				

Are you presently taking medications? Include any over-the-counter drugs, especially vitamins or herbal preparations. _____ Yes _____ No

If yes, please list with dosages.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you smoke? _____ Cigarettes _____ Pipe _____ Cigar _____ No

If so, how many packs/pipes/cigars per day? _____ *For how many years?* _____

If no, did you ever smoke? _____ Yes _____ No

Do you drink alcohol? _____ Hard liquor _____ Beer _____ Wine _____ No

If so, how many drinks do you have in a typical day? _____

Patient name _____

Medical history, continued

Have you ever had an operation? _____ Yes _____ No

If yes, please list the type of surgery, approximate year, hospital and physician's name.

1. _____
2. _____
3. _____
4. _____

Please list illness(es) that did not require an operation for which you were hospitalized.

Give dates, hospital, city and physician in charge.

Patient name _____

Family history

Are you married or do you have a significant other? _____ Yes _____ No

	Living?		Age or age at death	Present health or cause of death
	Yes	No		
Father				
Mother				
Spouse/significant other				

	Number living/dead	Health
Brother(s)		
Sister(s)		

	Age(s)	Health
Child(ren) living		
Child(ren) dead		

Please check any illness that has occurred in any of your blood relatives.

_____ Diabetes
_____ Bleeding tendency
_____ Tuberculosis
_____ Strokes
_____ Nervous illness
_____ Cancer
_____ Kidney disease
_____ Heart trouble
_____ High blood pressure
_____ Allergies

Patient name _____

Review of systems

Mark the appropriate response if any of the following have been a problem recently.

	Yes	No	Don't know		Yes	No	Don't know
Weight loss				Anxiety attacks			
Weight gain				Nervous breakdown			
Fatigue				Depression			
Rashes				Nausea			
Itching				Vomiting			
Change in skin color				Diarrhea			
History of anemia				Constipation			
Easy bruising or bleeding				Abdominal pain			
Change in vision				Change in bowel movements			
Do you wear glasses				Excessive gas			
History of glaucoma				Rectal bleeding			
Ear problems				Gallbladder disease			
Nosebleeds				Hemorrhoids			
Sinus problems				Ulcer disease			
Dentures				Hepatitis			
Frequent colds				Polyps in colon			
Shortness of breath				Colitis			
Wheezing				Excessive urination			
Chronic cough				Burning on urination			
Bloody phlegm				Difficulty urinating			
Pneumonia				Urinary hesitancy			
Bronchitis				Urinary dribbling			
Tuberculosis				Urinary frequency			
Asthma				Urinary infections			
Recent chest X-ray				Kidney stones			
Swelling of legs				Veneral disease			
Abnormal heartbeat				Air passage on urination			
Chest pain				Joint pains			
Heart murmur				Arthritis			
Heart attack				Joint swelling			
Abnormal EKG				Muscle pain			
Neurologic disease				Leg cramps			
Seizures				Thyroid disease			
Frequent headaches				Diabetes mellitus			
History of stroke				High cholesterol			

Patient name _____

Review of systems: For men

	Yes	No	Don't know
Penile discharge or lesions			
Testicular pain or mass			
Impotence			

Review of systems: For women

	Yes	No	Don't know
Vaginal bleeding			
Unusual menstrual bleeding			
Abnormal pap spear			
Breast pain			
Breast mass			
Breast discharge			
Abnormal mammogram			

Have you ever had a mammogram? _____ Yes _____ No

Date of last period _____

Periods are _____ Regular _____ Irregular

Number of pregnancies _____

Number of miscarriages _____

Have you taken oral contraceptives? _____ Yes _____ No

Have you had any recent weight loss or gain? _____ Yes _____ No