**SUSAN LUCAK, MD**

**FIRST VISIT QUESTIONNAIRE**

**WELCOME! Please fill out this QUESTIONNARE as best as you can.**

LAST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FIRST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_

Are you **allergic t**o any **medications**? No\_\_\_ Yes\_\_\_ If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any other **substances**? Please list them\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What **MEDICATIONS** are you **CURRENTLY** taking?

Name of Medication Dose Dose Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use laxatives? No Yes

Do you use anti-diarrheals? No Yes

What **vitamins** and **supplements** are you currently taking? Please list them.

**What symptom(s) or what reason(s) prompted this visit?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience **ABDOMINAL PAIN** in association with **your bowel movements**? No Yes

Is this pain worsened by **eating**? No Yes

What is **the location** of this pain? Please circle. **Lower abdominal (**bellow the belly button) **Upper abdominal** (above the belly button) **Both, upper and lower abdominal**

Do you experience **bloating?** No Yes Do you experience **flatulence**? No Yes

How often do you move your bowels?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What **stool consistencies** have you seen off all laxatives /anti-diarrheals or medications used to treat gastrointestinal symptoms? Please circle all that apply.

**(Hard balls) (Formed + smooth ) (Semi-formed ) (Lumpy) (Soft) (Watery) (Formed with cracks)**

Do you experience **straining**? No YesDo you experience **a sense of incomplete evacuation**? No YesDo you experience **stool urgency?** No YesDo you experience **stool incontinence**? No Yes Have you seen **blood** in your stool? No Yes

If you experience **UPPER abdominal pain**, do you also experience **abdominal fullness** with or after eating? No Yes

Do you experience any of the following? Please circle. Heartburn Acid reflux Belching Nausea Vomiting

Have you lost weight? How many pounds over what period of time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been previously diagnosed with any of the following conditions? Please circle.

GERD (acid reflux) IBS Celiac Disease Diverticulosis

Crohn’s Disease Ulcerative Colitis Helicobacter pylori infection

Colon cancer Other gastrointestinal cancer(s). Please specify.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What **gastrointestinal tests** have you had in the past? Please circle.

Upper endoscopy Colonoscopy CT Scans of Abdomen and Pelvis

Pill Camera Study MRI of Abdomen and Pelvis

Other tests (please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing any of the following **non-gastrointestinal symptoms**? Please circle.

frequent headaches jaw pains joint pains

urinary frequency pelvic pain low back pain

Is there **a FAMILY HISTORY** of any of the following illnesses?

Colon Cancer Celiac Disease Crohn’s Disease Ulcerative Colitis

Other\_\_\_\_\_\_\_\_\_

What **MEDICAL PROBLEMS** have you been diagnosed with in the past?

Year of diagnosis Medical Problem

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What **SURGERIES** have you had and when?

Year of Surgery Type of Surgery

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PSYCHIATRIC HISTORY**. Does stress worsen your gastrointestinal symptoms? No Yes

Have you been diagnosed with any of the following? Please circle.

Anxiety Panic attacks Clinical Depression

Obsessive-compulsive disorder Post-traumatic stress disorder

Anorexia nervosa Bulimia Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What psychopharmacologic medications have you taken in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been in therapy? Which type? Please circle. Psychotherapy

Cognitive Behavior Therapy (CBT)

**DIET.** Are you following any special diet? No\_\_ Y es\_\_\_ If yes, what type of diet do you follow? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have LACTOSE intolerance? No Yes

Do you have WHEAT (gluten) intolerance? No Yes

**HABITS and SOCIAL HISTORY.**

How much alcohol do you consume per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a former smoker? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current smoker\_\_\_\_\_\_\_\_ Never Smoker\_\_\_\_\_\_\_

Have you used smokeless tobacco? Yes\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your marital status? Please circle. Single Married Divorced Widowed Partnership

How many children do you have and what are their ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is or was your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN MEN**

Do you have any gynecologic problem(s)? Do you have any prostate problems?

Is there any pertinent information that you feel would be important for me to know? Please describe briefly.