Dr. Laura Stinton, MD, FRCPC
Gastroenterology/Hepatology
Health Questionnaire
(The contents of this form will be kept confidential)

Name: ____
Date of Birth: ____________________ Age: ____________________
Marital Status: __________________ Spouse's Name: ____________________
Occupation: ____________________ Number of Children: ________________
Reason for being referred (if known): ________________________________
____
Have you received previous medical treatment or consultation for any abnormality of your liver?
_____ Date_______________ Diagnosis or details if known____________________
____

Please indicate "Yes" or "No" to the following:
Liver History: Do you have a history of:

Jaudice (yellowing of the skin or eyes)	YES☐	NO☐
Swelling or fluid accumulation of your legs or abdomen	YES☐	NO☐
Confusion, Slow Thinking, Poor Memory	YES☐	NO☐
Vomiting of blood or passing black tarry stools	YES☐	NO☐
Itchy skin	YES☐	NO☐
Pale or clay colored stool	YES☐	NO☐

If you answered "YES" to any of the above, please provide any additional information (i.e. date, details) ____
____

Gastrointestinal History: Do you have a history of:

Difficulty Swallowing	YES☐	NO☐
Heartburn	YES☐	NO☐
Nausea/Vomiting	YES☐	NO☐
Abdominal Pain	YES☐	NO☐
Blood in your Stool	YES☐	NO☐
Recent change in bowel habits	YES☐	NO☐
Diarrhea	YES☐	NO☐
Constipation	YES☐	NO☐
Unexplained Weight Loss	YES☐	NO☐

If you answered "YES" to any of the above, please provide any additional information (i.e. date, details) ____
____
____

How many times a day/week do you have a bowel movement? ____________________
Have you ever had a colonoscopy? _____ When & Where? ____________________
Results if known: ____

Risk Factors for Liver Disease: Do you have a history of:

Blood or Blood Product Transfusion	YES☐	NO☐	What year?_________
Needle Stick Injury?	YES☐	NO☐	What year?_________
Tattoo?	YES☐	NO☐	What year?_________
Use of illegal drugs (i.e. Heroine, Cocaine)	YES☐	NO☐	What year?_________

What is your current weight? ____

What is the heaviest you have weighed? ___________________________________

How much did you weigh in your 20s? ____________________________________

Medical History: Do you have a history of:

High Blood Pressure	YES☐	NO☐
High Cholesterol	YES☐	NO☐
Heart Attack	YES☐	NO☐
Abnormal Heart Rhythm	YES☐	NO☐
Diabetes	YES☐	NO☐
Kidney Disease	YES☐	NO☐
Blood Clot (legs/lungs)	YES☐	NO☐
COPD/Emphysema	YES☐	NO☐
Asthma	YES☐	NO☐
Thyroid Disease	YES☐	NO☐
Arthritis	YES☐	NO☐

Other: ____

Past Surgical History:

Type: **Date:**

1)____

2)____

3)____

4)____

Current Medications:

Please list any medications (including Prescription, Over-the-Counter, Herbal supplements, etc)

1)______________________________5)________________________________

2)______________________________6)________________________________

3)______________________________7)________________________________

4)______________________________8)________________________________

Allergies: ____

Social History:

Do you smoke? _____If Yes, how many per day & for how many years: ____________

How many drinks of alcohol do you have in 1 week:___________________________

Do you have a history of heavy alcohol use?___________________________________

Do you currently use any illicit drugs? (i.e. Marijuana, Cocaine, etc.)______________

Family History

Do you have a family history of any of the following:

			Relationship to you? Age at Diagnosis:
Liver Disease	YES☐	NO☐	____________________________________
Liver Cancer	YES☐	NO☐	____________________________________
Colon Cancer	YES☐	NO☐	____________________________________
Colonic Polyps	YES☐	NO☐	____________________________________
Stomach Cancer	YES☐	NO☐	____________________________________
Esophageal Cancer	YES☐	NO☐	____________________________________
Gynecological Cancer	YES☐	NO☐	____________________________________
Celiac Disease	YES☐	NO☐	____________________________________
Inflammatory Bowel Disease (Crohn's/Ulcerative Colitis)	YES☐	NO☐	____________________________________