Patient Name:_____
MR: _____
Date:_____

Inflammatory Bowel Disease Medical Exam Questionnaire

Name_____ DOB___/___/____ Age____ Marital Status_____ Race____

Gender M / F Height _____ Present Weight _____ Usual Weight _____

Insurance ____ ____ Yes No Managed Care ____ ____ Yes No Self referral ____ ____ Yes No

Primary Care Physician	Referring Physician (if different from PCP)	Pharmacy
Name_____	_____	_____
Address_____	_____	Phone(____)_____
City_____	_____	Fax(_____)_____
Phone(_____)_____	(_____)_____	

How would you rate your present health? Excellent_____ Good____ Fair____ Poor_____

What type of Inflammatory Bowel Disease have you been diagnosed with?

a. Crohn's disease_____ b. Ulcerative Colitis_____ c. Indeterminate Colitis _____

d. Collagenous Colitis _____e. Lymphocytic Colitis_____ f. Other_____

How old were you when you were diagnosed? _____

How old were you when you began having symptoms? _____

Have you ever had an operation for the Inflammatory Bowel Disease? Yes____ No____

If yes, please indicate the type of surgery and the date(s) you had surgery:

Bowel Resection _____ Stricture Repair (stricturoplasty) _____

Ostomy _____ Complete colectomy with Ileal pouch anal anastomosis _____

Abscess Drainage _____ Appendectomy _____

Perianal surgery (fistula repair, seton placement, sphincterectomy, abscess drainage) _____

Have you had any other operations? Yes _____ No_____

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

1._____

2._____

3._____

4._____

Patient Name:_____

Inflammatory Bowel Disease Medical Exam Questionnaire

Please list illness(es) that did not require an operation for which you were hospitalized. *(Give dates, hospital, city and physician in charge.)*

_____

_____

_____

Have you ever had Pouchitis? Yes____ No_____ Don't Know_____ N/A _____

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_____

Are you currently taking medications? Yes ____ No _____
(Include any OTC drugs, especially vitamins or herbal preparations. If yes, please list with dosages.)*

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

*OTC = Over-The-Counter medications – prescription is not required.

Do you have any allergies to medications? *(if yes, list drug and the reaction it caused)*

_____

Have you ever been on steroids? Yes _____ No_____ *If yes, have you been on:*

Oral steroids (prednisone, budesonide, Entocort) _____ Date last taken _____

IV steroids _____ Date last taken _____

Steroid enemas or suppositories (Proctofoam, etc.) _____ Date last used _____

Have you ever taken any of these medications? *If yes, what dose were you taking and why did you stop taking it (nausea, other symptoms, wasn't working, couldn't afford it, etc.):*

Medication	Yes/No	Dose Used	Did it help your IBD? (Yes/No)	Reason for Stopping
Mesalamine				
6-MP				
Imuran				
Methotrexate				
Cyclosporine				
Sirolimus/Tacrolimus				
Remicade				
Humira				
Cimzia				
Tysabri				
Other study/experimental medications				

Patient Name:_____

Inflammatory Bowel Disease Medical Exam Questionnaire

Have you ever been diagnosed with a blood clot in your leg or your lungs? Yes_____ No____
*If yes, when?*_____

When was your last colonoscopy?_____

Have you ever had a Bone Densitometry Test (DEXA scan)? Yes_____ No____
*If yes, when?*_____

What was the result? Osteoporosis _____ Osteopenia _____ Normal _____ I don't know _____

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

When was the last time you saw your dentist?_____

Do you smoke? Yes _____ No _____ Cigarettes _____ Pipe_____ Cigar_____
*If yes, how many packs per day?*_____ For how many years?_____
If no, did you ever smoke? Yes _____ No_____ *If yes, when did you quit?* _____

Do you drink alcohol? Yes _____ No_____ Hard liquor_____ Beer_____ Wine_____
If yes, how many drinks do you have in a typical day? _____

Have you ever:

	Yes	No	Do not know
Had Rheumatic Fever			
Had Chicken Pox			
Received a blood transfusion			
Used intravenous drugs			
Been tested for Hepatitis A			
Been tested for Hepatitis B			
Been tested for Hepatitis C			
Been tested for HIV			
Been tested for Tuberculosis			

Have you received any of the following immunizations?

	Yes	No	Do not know	Date
Hepatitis A				
Hepatitis B				
Tetanus				
Pneumovax				
Annual Flu Vaccine				
Meningococcal Vaccine				
Zoster Vaccine				
Varicella Vaccine				
Human Papillomavirus Vaccine				

Patient Name:_____

Inflammatory Bowel Disease Medical Exam Questionnaire

Women Only

Are you sexually active? Yes_____ No _____
Form of birth control: _____
Have you ever had a Pap smear? Yes_____ No _____ Don't know _____
When was your last Pap smear? Date _____
Have you ever had a sexually transmitted disease? Yes_____ No _____ Don't know _____
Have you ever had genital warts? Yes_____ No _____ Don't know _____
Have you ever had an abnormal pap smear result? Yes_____ No _____ Don't know _____
Have you ever had a mammogram? Yes_____ No _____ Don't know _____
Abnormal mammogram Yes_____ No _____ Don't know _____
Number of Pregnancies _____ Number of miscarriages _____
Have you taken oral contraceptives? Yes_____ No _____ Don't know _____

Men Only

Are you sexually active? Yes_____ No _____
Form of birth control: _____
Have you ever had a sexually transmitted disease? Yes____ No _____ Don't know _____
Have you ever had genital warts? Yes_____ No _____ Don't know _____

FAMILY HISTORY

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

Are you married or have a significant other? Yes_____ No_____

Brothers # living _____ Health Problems?_____
dead _____ Health Problems?_____
Sisters # living _____ Health Problems?_____
dead _____ Health Problems?_____

Children living _____ Age(s)_____ Health Problems?_____
Children dead _____ Age(s) _____ Health Problems?_____

Please circle illness(es) which have occurred in any of your blood relatives:

Diabetes	Cancer	Easy Bleeding	Kidney disease	Tuberculosis
Heart trouble	Stroke	High blood pressure	Nervous illness	Allergies

Patient Name:_____

Inflammatory Bowel Disease Medical Exam Questionnaire

REVIEW OF SYSTEMS

Mark the appropriate response if any of the following has been a problem recently:

	Yes	No		Yes	No
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 bowels		
Do you wear glasses			Excessive gas		
History of glaucoma			Rectal bleeding		
Ear problems			Gallbladder disease		
Nose bleeds			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			Venereal disease		
Abnormal heart beats			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		