Washington University in St. Louis Physicians

Washington University IBD Program

New Patient History and Physical Exam

Please fill out and bring to appointment with medication list
READ CAREFULLY!

Name _____

Date of Birth ____ / ____ / ____

Dear Patient,

Welcome to the Washington University Inflammatory Bowel Disease Clinic. The Washington University Inflammatory Bowel Disease Clinic provides multi-disciplinary care to patients with known or suspected Crohn's disease and ulcerative colitis, as well as less common forms of inflammatory bowel disease (IBD) such as lymphocytic colitis, collagenous colitis, eosinophilic colitis and radiation entercolitis.

Experts in the medical management of IBD work closely with Washington University surgeons who are highly skilled in the most advanced procedural techniques when such approaches are required.

Physicians in other disciplines, including psychiatrists, rheumatologists, endocrinologists and dermatologists work closely through our center. We also work closely with pediatric gastroenterologists at St. Louis Children's Hospital to foster a smooth transition to care by an adult gastroenterologist. In addition, nutritionists and social workers focused on IBD are part of our healthcare team.

Our mission is to assist patients with their ongoing physical, nutritional, educational and psychosocial needs. We offer our patients the opportunity to participate in a wide variety of clinical trials.

In anticipation of your first visit, we ask that you complete the attached information forms. Please take the time necessary to thoroughly complete these forms as accurately as possible. If you need assistance with the completion of these forms, please call our office and we will be happy to assist you.

In order to achieve a thorough evaluation, it is important that you have sent or faxed (314-747-2460) the following items:

- Your most recent colonoscopy report as well as your first colonoscopy report along with the pathology reports
- Surgical reports and surgical pathology reports
- Radiographic imaging reports from the past year
- Discharge summaries from any hospitalizations from this past year

We look forward to seeing you at your scheduled appointment.

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help. We want you to live a healthier life.

Name _____

Date of Birth ____ / ____ / ____

PATIENT INFORMATION

Name _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female

PHYSICIAN INFORMATION

Name of Primary Care Physician _____

Name of Referring Physician _____

CURRENT PROBLEM

1. **You have:** ☐ Crohn's Disease (CD) ☐ Ulcerative Colitis (UC) ☐ Indeterminate Colitis
   Year Diagnosed _____

2. **Current symptoms:**
   Do you have diarrhea? ☐ Yes ☐ No
   Number of bathroom trips in 24 hours? _____
   Do you have blood in stool? ☐ Yes ☐ No
   Do you have abdominal pain? ☐ Yes ☐ No
   Do you have a fever? ☐ Yes ☐ No
   Do you have other symptoms? ☐ Yes ☐ No
   If yes please describe _____

3. **Overall you feel:** ☐ 1 Can't take it anymore ☐ 2 Miserable ☐ 3 Okay ☐ 4 Pretty good ☐ 5 Great

RELATED PROBLEM(S)

4. Please check if you currently have or have had any of the following problems related to CD/UC:

☐ Now	☐ Past	Pyoderma gangrenosum	☐ Now	☐ Past	Erythema nodosum
☐ Now	☐ Past	Iritis	☐ Now	☐ Past	Weight gain
☐ Now	☐ Past	Uveitis	☐ Now	☐ Past	Fever
☐ Now	☐ Past	Back stiffness/pain	☐ Now	☐ Past	Anal fissures
☐ Now	☐ Past	Perianal fistulas or abscesses	☐ Now	☐ Past	Fatigue
☐ Now	☐ Past	Joint pain	☐ Now	☐ Past	Mouth ulcers
☐ Now	☐ Past	Kidney stones	☐ Now	☐ Past	Night sweats
☐ Now	☐ Past	Bowel urgency	☐ Now	☐ Past	Bowel obstruction
☐ Now	☐ Past	Incontinence of stool	☐ Now	☐ Past	Liver disease
☐ Now	☐ Past	Weight loss	☐ Now	☐ Past	Abdominal abscess

Please describe any other symptoms related to CD/UC _____

_____

Please don't forget to send or fax (314-747-2460):

☐ Your most recent colonoscopy report as well as your first colonoscopy report along with the pathology reports

☐ Surgical reports and surgical pathology reports

☐ Radiographic imaging reports from the past year

☐ Discharge summaries from any hospitalizations from this past year

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Date of Birth ____ / ____ / _____

SURGERIES FOR CD/UC

5. Please check if you've had any of the following. Provide date(s) on the line.

- ☐ Resection _____
- ☐ Abscess _____
- ☐ Fistula _____
- ☐ Colectomy _____
- ☐ Proctectomy _____
- ☐ Ileocecectomy _____
- ☐ Appendectomy _____
- ☐ Strictureplasty _____
- ☐ Stoma/reversal _____
- ☐ Other _____

HOSPITALIZATIONS

6. Have you ever been hospitalized for CD/UC, not including surgeries listed above? ☐ Yes ☐ No
If yes, complete below:

Name of Hospital	Date	Name of Hospital	Date

SCREENING

7. Date of last colonoscopy/upper endoscopy/ flexible sigmoidoscopy/ileoscopy/enteroscopy _____

8. Most recent TB skin test (PPD): ☐ Positive ☐ Negative Date of last test _____

9. Most recent chest X-ray: Date _____ Results _____

MEDICATIONS

10. Current CD/UC Medications	Frequency and Dose	Date Started

Examples Include: Remicade, Humira, Cimzia, Tysabri, Asacol, Pentasa, Lialda, Colazal, Sulfasalazine (Azulfidine), Ciprofloxacin, Metronidazole, Azathioprine (Imuran), 6-Mercaptopurine, Methotrexate, Prednisone, Cyclosporine, Rowasa enemas, Canasa suppositories, Hydrocortisone enemas or foam

11. Prior CD/UC Medications	Did it work?	Prior CD/UC Medications	Did it work?
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No
	☐ Yes ☐ No		☐ Yes ☐ No

12. Prednisone Use

How many courses of steroids do you take in a year?

How many days are there in a course?_____ How many milligrams of prednisone in one course?____

13. Other Current Medications

Your healthcare is very important to us.

Thank you for choosing

Washington University Physicians.

Name _____

Date of Birth ____ / ____ / ____

14. Medication Allergies

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

15. Check if any family members have any the following? Provide relationship(s) on line.

	Relationship to You		Relationship to You
☐ Crohn's disease	_____	☐ Cancer	_____
☐ Ulcerative colitis	_____	☐ Ulcers	_____
☐ Colon or rectal cancer	_____	☐ Heart disease	_____
☐ Diabetes	_____	☐ Liver disease or kidney disease	_____
☐ High blood pressure	_____	☐ Other significant medical problems	
☐ Rheumatoid arthritis	_____		_____
☐ Lupus	_____		_____

DEMOGRAPHIC INFORMATION

16. Please check all that apply.

Hispanic: ☐ Yes ☐ No ☐ Unknown

Jewish: ☐ Yes ☐ No ☐ Unknown

Are any of your grandparents of Jewish descent?

Paternal: *Grandfather:* ☐ Yes ☐ No ☐ Unknown *Grandmother:* ☐ Yes ☐ No ☐ Unknown

Maternal: *Grandfather:* ☐ Yes ☐ No ☐ Unknown *Grandmother:* ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other (specify)_____

BLEEDING HISTORY

17. Please check all that apply.

☐ Excessive bleeding ☐ Easy bruising ☐ Aspirin use ☐ Coumadin use ☐ Other _____

REVIEW OF SYSTEMS

18. Please check all that apply.

Constitution
- ☐ Night sweats
- ☐ Fevers
- ☐ Chills

Skin
- ☐ Change in size/ color of moles
- ☐ Rash
- ☐ Bruising

ENMT
- ☐ Pain
- ☐ Deafness
- ☐ Ringing in ears
- ☐ Hoarseness
- ☐ Sinus drainage
- ☐ Nose bleeds

Cardiac
- ☐ Palpitations
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Fatigue

Respiratory
- ☐ Cough
- ☐ Production of sputum
- ☐ Coughing of blood
- ☐ Pain

Gastrointestinal
- ☐ Painful swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Tarry stools
- ☐ Yellow jaundice
- ☐ Bloody stools
- ☐ Change in bowel movements

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help. We want you to live a healthier life.

Name _____

Date of Birth ____ / ____ / ____

REVIEW OF SYSTEMS continued

Genitourinary
- ☐ Kidney/bladder disease
- ☐ Decreased urine stream
- ☐ Unable to urinate
- ☐ Painful urination
- ☐ Blood in urine

Musculoskeletal
- ☐ Weakness
- ☐ Trauma
- ☐ Limited motion
- ☐ Bone/joint deformity

Endocrine
- ☐ Change of appetite
- ☐ Excessive thirst/urination
- ☐ Goiter

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

Neurological
- ☐ Paralysis
- ☐ Weakness
- ☐ Seizure
- ☐ Fainting
- ☐ Headaches/ Migraines
- ☐ Incoordination
- ☐ Head trauma
- ☐ Numbness/Tingling in extremities

Hematologic
- ☐ Swollen lymph nodes
- ☐ Bleeding disorders

Immune System
- ☐ Immune disorders

OTHER HISTORY

19. Please check all that apply.

- ☐ Herpes zoster
- ☐ Glaucoma
- ☐ Ankylosing spondylitis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteonecrosis
- ☐ Hepatitis
- ☐ EBV (mononucleosis)
- ☐ HPV (human papilloma virus)
- ☐ Hyperactive/ Hypoactive thyroid
- ☐ Diabetes
- ☐ Fatty liver disease
- ☐ PBC (primary biliary cirrhosis)
- ☐ PSC (primary sclerosis cholangitis
- ☐ HIV/AIDS
- ☐ Seizures
- ☐ Stroke
- ☐ Asthma
- ☐ High blood pressure
- ☐ Kidney/Bladder disease
- ☐ Lung disease
- ☐ Heart disease

FEMALES ONLY

Please check all that apply.

Breast
- ☐ Lumps ☐ Pain ☐ Nipple discharge
- ☐ Infection ☐ Trauma
- ☐ Last mammogram _____

GYN
- ☐ Irregular periods ☐ Hormone therapy
- ☐ Menopause

Last pelvic exam/PAP smear _____

Last menstrual period _____

SOCIAL HISTORY

20. Please check all that apply.

Tobacco Use

☐ Never Smoked

☐ Currently Smoke
_____ pack(s) per day for _____ years

☐ Smoked in the past, but quit in_____
_____ pack(s) per day for _____ years

Do you drink alcohol? ☐ No ☐ Yes

If yes list number of drinks: Per day_____ or Per month_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ No ☐ Yes – How many_____ Age(s) _____

Work Status: ☐ Employed ☐ Student ☐ Unemployed ☐ On Disability ☐ Retired

Occupation _____

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