Patient questionnaire (A/P/2021) Date: ____ / ____ / 2024 Time:_____________

Name, surname, personal identification number: ______________________________________

Sex: W / M Age: ______ years old Height: ______ cm Weight: ______ kg

Language of communication: Latvian / Russian / English / Other: _________________________

Address of residence: ____

Phone and e-mail: ____

Profession, occupation: ____

General physician (name, surname, phone): ____

Physician who referred you to GASTRO: ____

Trusted person to contact in case of medical need (name and phone):

____

Date of previous visit to the Digestive Diseases Centre GASTRO: ________________________

The reason for today's visit, current health disorders, signs of illness:

____

____

____

Elevated body temperature, fever: NO / YES ___________________________________

Haemorrhaging, bloody discharge from the rectum: NO / YES _____________________________

Repeated vomiting: NO / YES ___________________________________

Hard to swallow food: NO / YES ___________________________________

Increasing weakness: NO / YES ___________________________________

Dizziness: NO / YES ___________________________________

Loss of consciousness: NO / YES ___________________________________

Unexplained weight loss: NO / YES ___________________________________

Please continue on the other side

Other diseases, current and former, health disorders, **surgeries**:

____

____

____

All the medicinal products, other medicines used in the past 7 days:

____

____

____

____

Special diet, eating restrictions, disorders, intolerance to food ingredients:

____

Allergies, drug intolerance and adverse events:

____

Tobacco and nicotine products, smoking (history of use, doses):

____

Alcohol (history of use, doses):

____

Addictions to other substances (name, route of administration, history of use, doses):

____

Other known harmful environmental, occupational, or household factors, and other important information about yourself:

____

Congenital or oncological diseases of the **first-degree relatives** (children, siblings, parents):

Polyp, tumour, or cancer of the colon or rectum: NO / YES ________________________________

Tumour or cancer of the stomach: NO / YES ____________________________________

Coeliac disease NO / YES ____________________________________

Patient's signature: