Patient questionnaire (A/P/2021) Date: ____ / ____ / 2021 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: