

Date: \_\_\_\_\_

Rm#: \_\_\_\_\_

Age: \_\_\_\_\_  Pt. speaks Spanish

**SYMPTOMS & NUTRITION FORM**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Referred By: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_

Please provide names of other physician(s) that you have visited within the last year:

\_\_\_\_\_

Reason(s) for your visit to a Gastroenterologist (please include duration of your symptoms if applicable):

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Have you been experiencing any of the following? (place a check mark next to those that apply to you):

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Nausea  | <input type="checkbox"/> Chest pain                                  | <input type="checkbox"/> Stool incontinence (i.e. loss of control of bowel movements) |
| <input type="checkbox"/> Vomiting  | <input type="checkbox"/> Shortness of breath                         | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Burning in chest  | <input type="checkbox"/> Coughing                                    | _____   |
| <input type="checkbox"/> Acid or bitter taste in the back of your throat                           | <input type="checkbox"/> Abdominal bloating                          | _____   |
| <input type="checkbox"/> Voice hoarseness  | <input type="checkbox"/> Abdominal pain                              |   |
| <input type="checkbox"/> Awakening in the middle of the night with coughing or shortness of breath | <input type="checkbox"/> Diarrhea                                    | <input type="checkbox"/> COVID-19 Vaccine   |
| <input type="checkbox"/> Sensation of food being stuck in your throat or chest after swallowing    | <input type="checkbox"/> Constipation                                | <input type="checkbox"/> Johnson & Johnson  |
| <input type="checkbox"/> Pain when you swallow   | <input type="checkbox"/> Thinning of the stool on a consistent basis | <input type="checkbox"/> Moderna Date: 2 <sup>nd</sup> dose _____                     |
| <input type="checkbox"/> Loss of appetite  | <input type="checkbox"/> Rectal bleeding                             | <input type="checkbox"/> Pfizer Date: 2 <sup>nd</sup> dose _____                      |
| <input type="checkbox"/> Feeling full shortly after starting a meal                                | <input type="checkbox"/> Pain in rectal area                         | <input type="checkbox"/> Booster Date: _____  |
|  | <input type="checkbox"/> Black stool                                 |   |
|  | <input type="checkbox"/> Unintentional weight loss                   |   |
|  | <input type="checkbox"/> Fever and/or chills                         |   |

Please describe any other symptoms you have been experiencing that are not listed above:

\_\_\_\_\_

\_\_\_\_\_

**For FEMALE Patients only:**

- Is there any correlation between your symptoms and your menstrual period?  YES  NO  
If yes, please briefly describe: \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_

Are you or could you be pregnant at this time?  YES  NO

Please place a check mark next to any of the following that apply to you:

- |  |   |
|--|---|
| <input type="checkbox"/> Irregular menses                            | <input type="checkbox"/> Vaginal bleeding between menstrual periods |
| <input type="checkbox"/> Excessive bleeding during menstrual periods | <input type="checkbox"/> Abnormal vaginal secretions                |

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**For office use only**

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BMI: \_\_\_\_\_ Temp: \_\_\_\_\_ BP: \_\_\_\_\_ HR: \_\_\_\_\_

Medical Clearance:  YES  NO  Other: \_\_\_\_\_ Diabetes:  YES  NO Insulin:  YES  No

Please provide the names and doses of the medications you are currently taking:

Medication	Dose	Frequency

Please provide a list of any medical disorders, emergency room visits, hospitalizations and/or surgeries since your last visit:

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Have you experienced a heart attack, stroke or similar cardiovascular event since your last visit?

Yes  No If yes, Please list:

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Have you experienced an infection with methicillin-resistant staph aureus (MRSA) or an infection with other organism resistant to antibiotics: If so, please list:

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**Dietary History:**

Please describe the foods you typically have for the following meals:

	Food	Beverage
Breakfast		
Lunch		
Dinner		
Snack		

Do you have a history of milk or other food intolerance?  Yes  No If yes, please describe:

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Do any of your symptoms occur either during or shortly after meals? If yes, please describe:

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Do you chew gum or consume other products containing sugar on a regular basis?  Yes  No If yes, please describe:

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