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):

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

□ Nausea
□ Vomiting
□ Burning in chest
□ Acid or bitter taste in the back of your throat
□ Voice hoarseness
□ Awakening in the middle of the night with coughing or shortness of breath
□ Sensation of food being stuck in your throat or chest after swallowing
□ Pain when you swallow
□ Loss of appetite
□ Feeling full shortly after starting a meal
□ Chest pain
□ Shortness of breath
□ Coughing
□ Abdominal bloating
□ Abdominal pain
□ Diarrhea
□ Constipation
□ Thinning of the stool on a consistent basis
□ Rectal bleeding
□ Pain in rectal area
□ Black stool
□ Unintentional weight loss
□ Fever and/or chills
□ Stool incontinence (i.e. loss of control of bowel movements)
□ Other: _____
_____
_____
□ COVID-19 Infection _____
_____

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:

□ Irregular menses
□ Excessive bleeding during menstrual periods
□ Vaginal bleeding between menstrual periods
□ Abnormal vaginal secretions

For office use only

□ Risk Reduction □ Diverticulosis/Diverticulitis □ High Fiber Diet □ Hemorrhoids

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:

_____
_____
_____
_____

Have you experienced a heart attack, stroke or similar cardiovascular event since your last visit?
□ Yes □No If yes, Please list:

_____
_____

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

_____
_____

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:

_____

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

_____

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

_____