Date: _____ Rm#_____ Age:_____ □Pt. speaks Spanish

Symptoms and Nutrition Form

Last Name:_____ First Name_____ Middle Initial ____

Referred By: _____ Primary Care Doctor: _____

Please provide a list of other physician(s) that you have visited within the past year:

_____

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

_____

Have you been experience 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
- □ Blood in urine
- □ Pain when you urinate
- □ 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)
- □ Night sweats
- □ Rash in any part of your body
- □ Headache
- □ Sudden change in vision
- □ Eye pain
- □ Other : _____

_____

_____

For FEMALE Patients only:

- Is there any correlation between your symptoms and your menstrual period? □Yes □No

  If yes, please briefly describe: _____

  Date of your last menstrual period: _____

  Are you or could you be pregnant at this time? □Yes □ No

Place a check mark next 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

Weight: _____ Height: _____ BMI:_____ Temp: _____ BP: _____ HR: _____ Other: _____

Medical Clearance: □Yes □No Diabetic: □Yes □No Insulin Dependent: □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 methicilin-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		
Snacks		

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

Do any of your symptoms occur 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:

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