Vomiting		Last Name: First Na	me	Middle In	itial	
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 Shortness of breath Coughing 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 Sensation of food being stuck in your throat or chest after swallowing Constipation Black stool Chest pain For FEMALE Patients only: Is there any correlation between your symptoms and your menstrual period? Date of your last menstrual period: Are you or could you be pregnant at this time? Dres DNo Place a check mark next any of the following that apply to you: Irregular menses Shortness of breath Coughing Fever and/or chills Stool incontinence (i.e. loss of control of bowel movements; Night sweats Nobleminal pain Night sweat	Referred By: Primary Care Doctor: _					
Have you been experience any of the following? (place a check mark next to those that apply to you): Nausea Shortness of breath Coughing Fever and/or chills		Please provide a list of other physician	n(s) that you have visited w	within the	past year:	
Nausea			cerologist (please include o	duration o	f your symptoms if	
Vomiting		Have you been experience any of the f	following? (place a check r	mark next	to those that apply to you):	
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 Bain when you swallow Loss of appetite Feeling full shortly after starting a meal Chest pain For FEMALE Patients only: Blood in urine Pain when you urinate control of bowel movements; Night sweats Night specification Night sweats Night specifica						
Acid or bitter taste in the back of pain when you urinate your throat abdominal bloating had bloating with coughing or shortness of breath with coughing or shortness of breath awith coughing or shortness of breath being throat or chest after swallowing consistent basis consistent basis are pain when you swallow are pain in rectal area Black stool Unintentional weight loss are pain between your symptoms and your menstrual period? The you or could you be pregnant at this time? The your bod Headache Sudden change in vision Eye pain Other: Thinning of the stool on a page year in throat or chest after swallowing consistent basis other: Thinning of the stool on a page year in throat or chest after swallowing consistent basis other: Thinning of the stool on a page year in throat or chest after swallowing consistent basis other: Thinning of the stool on a page year in throat or chest after swallowing consistent basis other: Thinning of the stool on a page year in throat or chest after swallowing consistent basis other: Thinning of the stool on a page year in throat or chest after swallowing the stool on a page year in throat or chest after swallowing the stool on a page year in throat or chest after swallowing the stool on a page year in throat or chest after swallowing the stool on a page year in throat or chest after swallowing year in throat or chest after swallowing the stool on a page year in throat or chest after swallowing in the abdominal pain page your bod Headache Sudden change in vision Eye pain Other: Thinning of the stool on a page year in throat or chest after swallowing in the abdominal pain page your bod Headache Sudden change in vision Eye pain Other: Thinning of the stool on a page year in throat or chest after swallowing in the abdominal pain page year in throat or chest after swallowing in the abdominal page year in throat or chest after swallowing in the abdominal page year in throat or chest after swallowing in the abdominal page year in throat or chest after swallowing in the abdominal pa			DI II			
your throat Voice hoarseness Abdominal bloating Night sweats Abdominal pain Rash in any part of your bod 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 For FEMALE Patients only: Is there any correlation between your symptoms and your menstrual period? PYes □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 Night sweats Night sweats Nash in any part of your bod Headache Sudden change in vision Eye pain Other: Other: Sudden change in vision Eye pain Other: Other: Date of your starting a Black stool Unintentional weight loss Other: Pain in rectal area Black stool Unintentional weight loss Other: Abdominal bloating Pash in any part of your bod Headache Sudden change in vision Eye pain Other: Other: Other: Pain in rectal area Black stool Unintentional weight loss Other: Are you or could you between your symptoms and your menstrual period? □Yes □No Place a check mark next any of the following that apply to you: Irregular menses		_			Stool incontinence (i.e. loss o	
Voice hoarseness	1					
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 consistent basis Other: Pain when you swallow Rectal bleeding Loss of appetite Pain in rectal area Black stool Unintentional weight loss Chest pain For FEMALE Patients only: Is there any correlation between your symptoms and your menstrual period? Pain wenstrual period: Are you or could you be pregnant at this time? Pass No Place a check mark next any of the following that apply to you: Irregular menses Vaginal bleeding between menstrual periods Vaginal bleeding between menstrual periods]	-	_		_	
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 Peeling full shortly after starting a meal Chest pain For FEMALE Patients only: Is there any correlation between your symptoms and your menstrual period? Date of your last menstrual period: Are you or could you be pregnant at this time? Pain in rectal area Black stool Unintentional weight loss Unintentional weight loss Are you or could you be pregnant at this time? Pan No Place a check mark next any of the following that apply to you: Irregular menses Unintentional weight loss Vaginal bleeding between menstrual periods			 Diarrhea 			
Sensation of food being stuck in your throat or chest after swallowing consistent basis Other: Pain when you swallow Rectal bleeding Loss of appetite Pain in rectal area Feeling full shortly after starting a Black stool meal Unintentional weight loss Chest pain For FEMALE Patients only: Is there any correlation between your symptoms and your menstrual period? Period.		_				
throat or chest after swallowing consistent basis Other: Pain when you swallow Rectal bleeding Loss of appetite Pain in rectal area Feeling full shortly after starting a Black stool Meal Unintentional weight loss Chest pain For FEMALE Patients only: Is there any correlation between your symptoms and your menstrual period? a Yes a No If yes, please briefly describe: Date of your last menstrual period: Are you or could you be pregnant at this time? a Yes a No Place a check mark next any of the following that apply to you: Irregular menses Vaginal bleeding between menstrual periods]	Sensation of food being stuck in your	-			
Pain when you swallow Loss of appetite Pain in rectal area Feeling full shortly after starting a Black stool Unintentional weight loss Chest pain 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 Useful area Vaginal bleeding between menstrual periods		throat or chest after swallowing	_			
Loss of appetite)	Pain when you swallow				
meal □ Unintentional weight loss Chest pain For FEMALE Patients only: Is there any correlation between your symptoms and your menstrual period? □Yes □No If yes, please briefly describe: □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □)	Loss of appetite				
Chest pain 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 □ Vaginal bleeding between menstrual periods]	Feeling full shortly after starting a	 Black stool 			
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 □ Vaginal bleeding between menstrual periods		meal	 Unintentional weight 	loss		
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 □ Vaginal bleeding between menstrual periods)	•				
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 □ Vaginal bleeding between menstrual periods		For FEMALE Patients only:				
Date of your last menstrual period: Are you or could you be pregnant at this time? Place a check mark next any of the following that apply to you: Irregular menses Uaginal bleeding between menstrual periods		• Is there any correlation between	en your symptoms and you	ur menstr	ual period? □Yes □No	
Are you or could you be pregnant at this time? Place a check mark next any of the following that apply to you: Irregular menses U Vaginal bleeding between menstrual periods		If yes, please briefly describe:				
Place a check mark next any of the following that apply to you: Irregular menses Uaginal bleeding between menstrual periods		Date of your last menstrual period:				
Irregular menses Vaginal bleeding between menstrual periods		Are you or could you be pregnant at this time? □Yes □ No				
Tregular menses		Place a check mark next any of the foll	owing that apply to you:			
Excessive bleeding during menstrual periods Abnormal vaginal secretions]	Irregular menses Uaginal bleeding between menstrual periods				
			s Abnormal vaginal	secretions		
For office use only			For office use only			

Rm#____

Date: ____

Age:_____ □Pt. speaks Spanish

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

Medication	Dose	Frequency
	7000	
		29,
		'
Please provide a list of any medi surgeries since your last visit:	cal disorders, emergency room v	isits, hospitalizations and/or
Have you experienced a heart at ☐ Yes ☐ No If yes, please list:	tack, stroke or similar cardiovasc	cular event since your last visit?
	To the same of the	(MDCA)
Have you experienced an infection other organism resistant to antib	on with methicilin-resistant staph	aureus (MRSA) or an infection with
Have you experienced an infection other organism resistant to antib	on with methicilin-resistant staph viotics? If so, please list:	aureus (MRSA) or an infection with
Have you experienced an infection other organism resistant to antib	on with methicilin-resistant staph iotics? If so, please list:	aureus (MRSA) or an infection with
other organism resistant to antib	on with methicilin-resistant staph iotics? If so, please list:	aureus (MRSA) or an infection with
other organism resistant to antib	oiotics? If so, please list:	
other organism resistant to antib	s you typically have for the follow	ving meals:
other organism resistant to antib	oiotics? If so, please list:	
other organism resistant to antibody Dietary History: Please describe the foods Breakfast	s you typically have for the follow	ving meals:
Other organism resistant to antibody Dietary History: Please describe the foods Breakfast Lunch	s you typically have for the follow	ving meals:
Dietary History: Please describe the foods Breakfast Lunch Dinner	s you typically have for the follow	ving meals:
Other organism resistant to antibody Dietary History: Please describe the foods Breakfast Lunch	s you typically have for the follow	ving meals:
Dietary History: Please describe the foods Breakfast Lunch Dinner	s you typically have for the follow Food	ving meals: Beverage
Dietary History: Please describe the foods Breakfast Lunch Dinner Snacks	s you typically have for the follow Food ther food intolerance? Yes No	Beverage If yes, please describe:
Dietary History: Please describe the foods Breakfast Lunch Dinner Snacks Do you have history of milk or of Do any of your symptoms occur	s you typically have for the follow Food ther food intolerance? during or shortly after meals? If you	Beverage If yes, please describe:

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

Medication	Dose	Frequency
Medication	Dosc	
		(-
Please provide a list of any medic surgeries since your last visit:	al disorders, emergency room vi	sits, hospitalizations and/or
Have you experienced a heart att		ular event since your last visit? aureus (MRSA) or an infection with
other organism resistant to antibi	otics? If so, please list:	,
Dietary History: Please describe the foods	you typically have for the follow	ing meals:
	Food	Beverage
Breakfast		
Lunch		
Dinner		
Snacks		
Do you have history of milk or otl	 ner food intolerance? □ Yes □ No	If yes, please describe:
Do any of your symptoms occur o	luring or shortly after meals? If y	ves, please describe:
Do you chew gum or consume oth please describe:	ner products containing sugar on	a regular basis? 🗆 Yes 🗆 No If yes,