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 □ Chest pain □ Stool incontinence (i.e. loss of

□ Vomiting □ Shortness of breath control of bowel movements)

□ Burning in chest □ Coughing □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Acid or bitter taste in the □ Abdominal bloating \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

back of your throat □ Abdominal pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Voice hoarseness □ Diarrhea

□ Awakening in the middle of the night □ Constipation □ COVID-19 Vaccine

with coughing or shortness of breath □ Thinning of the stool

□ Sensation of food being stuck in your on a consistent basis □Johnson & Johnson

throat or chest after swallowing □ Rectal bleeding □Moderna Date: 2nd dose \_\_\_\_\_\_\_

□ Pain when you swallow □ Pain in rectal area □Pfizer Date: 2nd dose \_\_\_\_\_\_\_

□ Loss of appetite □ Black stool □Booster Date: \_\_\_\_\_\_\_\_

□ Feeling full shortly after □ Unintentional weight loss

starting a meal □ 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:

□ Irregular menses □ Vaginal bleeding between menstrual periods

□ Excessive bleeding during menstrual periods □ Abnormal vaginal secretions

**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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

□ Yes □No If yes, Pleas 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_