

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):

- | | | |
|--|--|---|
| <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 nd dose _____ |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Pfizer Date: 2 nd 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 |

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, 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:
