

PATIENT NAME: _____ DOB: _____

CHIEF COMPLAINT: _____

PLEASE INDICATE IF YOU ARE HAVING ANY CURRENT PROBLEMS, SIGNS OR SYMPTOMS:

- General Wellness Eyes Skin Ears, Nose, throat Stomach/Digestion Lungs/Breathing
 Heart/Circulation Muscles/Joints/Bones Neurological Allergies Reproductive/Urinary
 Thyroid/Endocrine Psychiatric Blood/Lymph Other

PAST OR PRESENT MEDICAL CONDITIONS

- Anemia Heart Attack Diabetes Kidney Disease Thyroid Disorders
 Asthma COPD Stroke Hyperlipidemia Kidney Stones Hepatitis
 Atrial Fibrillation Congestive Heart Failure Hypertension Neurologic Disorder Sleep Apnea
 Cancer Coronary Artery Disease Valvular Heart Disease Colon Cancer

Other: _____

PREVIOUS GI PROCEDURES: () None

- Abdominal Surgery- Date _____ Cholecystectomy (gallbladder)- Date _____ Gastric Bypass- Date _____
 Colonoscopy- Date _____ EGD- Date _____ Capsule Study- Date _____ ERCP- Date _____
 CT SCAN- Date _____ ULTRASOUND- Date _____ MRI- Date _____
 SMALL BOWEL X RAYS- Date _____ Other Surgeries _____

PATIENT REVIEW OF SYSTEMS

Are you experiencing any of the following? (Please check all that apply)

Allergic Eye irritation Reactions Sneezing None

Cardiovascular (Heart) Pain in chest Palpitation/Fluttering of heart None
 Shortness of breath while exercising

General Blurred vision Irritation from light Itching Weight change Decreased appetite None
 Nose blocked Painful Eyes Post Nasal Drip Fever or Night sweats Fatigue or weakness
 Pressure in ears Rhinitis (runny nose) Sores in mouth Teeth hurt

Gastrointestinal Constipation Diarrhea Pain Reflux (heartburn) None

Genitourinary Hesitation when urinating Urination at night Pain when urinating Kidney stones None
 Blood in urine

Hematologic Bleeds easily Night sweats Weight loss None

Integumentary (Skin) Bleeding Dry Skin Itchy Skin Rash Lesions None

Musculoskeletal Cramping Soreness Weakness None

Neurological (Nerves) Abnormal movements Dizziness/Vertigo Fainting None
 Ringing in the ears Twitch

Psychiatric Depression Mood Swings Situational Stress None

Respiratory (Lungs) Cough Shortness of breath while sitting Wheezing None

Patient Signature: _____ **Date:** _____