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:**_____