GASTROENTEROLOGY, LTD.

CURRENT SYMPTOMS FORM

We ask that you complete this brief form to update your patient record and assist us during your visit.

Name: _____ Date of Birth: _____

Referring Physician: _____ Reason for Today's visit: _____

_____

Have there been any significant changes in your health since you were last seen in our office?

_____

_____

Medication List: Name Dosage Frequency

Updated Review of Systems: Please check (✓) any conditions that <u>currently</u> represent a SIGNIFICANT problem.

GASTROINTESTINAL			
	Yes (✓)		Yes (✓)
Abdominal pain	☐	Diarrhea	☐
Nausea and vomiting	☐	Constipation	☐
Heartburn or indigestion	☐	Rectal pain	☐
Loss of appetite	☐	Rectal bleeding	☐
Trouble swallowing	☐	Blood in stool	☐
Hemorrhoids	☐	Tarry stools	☐

General	Yes (✓)	Cardiovascular	Yes (✓)	Musculoskeletal	Yes (✓)
Fever or chills	☐	Chest pain	☐	Back pain	☐
Night sweats	☐	Heart palpitations	☐	Leg pain	☐
Recent weight changes	☐	Irregular heart beat	☐	Muscle weakness	☐
Ears, Nose, Mouth		Feet or ankle swelling	☐	**Neurologic**	
Nose bleeds	☐	**Genitourinary**		Numbness	☐
Sinus problems	☐	Painful urination	☐	Headaches	☐
Earache	☐	Urgency	☐	Dizziness	☐
Dentures	☐	Slow or small stream	☐	**Skin**	
Hearing loss	☐	Leaking of urine	☐	Rash, dryness, itching	☐
Pulmonary		Menstrual problems	☐	Jaundice	☐
Chronic cough, wheezing	☐	**Endocrine**		Easy bruising	☐
Shortness of breath	☐	Heat or cold intolerance	☐	Pigment changes	☐
		Hot flashes	☐	**Psychiatric**	
		Excessive thirst	☐	Depression	☐
		Flushing	☐	Anxiety	☐
				Other	

Patient signature _____ Date _____