

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE X- MARK EACH SYMPTOM AS YES  OR NO

**GENERAL**

**Y N**

- weight loss
- weight gain
- chronic fatigue
- chills
- fever

**EARS NOSE THROAT**

- sore throat
- hoarseness
- sinus problems
- nose bleeds

**CARDIOVASCULAR**

**Y N**

- coronary artery disease
- chest pain or pressure
- high blood pressure
- heart valve disease
- rapid heart beat
- irregular heart beat
- swelling in legs or feet

**RESPIRATORY**

- wheezing or asthma
- persistent cough
- bronchitis
- shortness of breath

**HEMATOLOGIC**

**Y N**

- enlarged glands / nodes
- abnormal bleeding
- anemia

**GENITOURINARY**

**Y N**

- frequent urination
- difficulty urinating
- blood in urine
- kidney stones
- kidney failure

**NEUROLOGIC**

- Seizures
- numbness or tingling
- stroke
- frequent headaches

**MUSCULOSKELETAL**

**Y N**

- Arthritis
- joint swelling
- osteoporosis
- Joint pain / stiffness
- Low back pain

**ENDOCRINE**

- Diabetes ( insulin / pills )
- Thyroid disease (hyper / hypo)
- Steroid use ( past / present )

**SKIN**

- allergic reactions
- skin rashes

**PSYCHIATRIC**

- anxiety
- depression
- memory loss
- mental illness

**GASTROINTESTINAL SYMPTOMS:**

**Y N**

- Indigestion
- Heartburn (daytime / nighttime)
- Nausea
- Vomiting
  
- Difficulty swallowing (solids/ liquids)
- Abdominal pain
  
- Jaundice
  
- Change in bowel habits
- Diarrhea
- Constipation
- Passing blood from the rectum
- Rectal pain
  
- Abdominal bloating
- Increased gas (flatus)
  
- Increased gas (belching)
- Loss of appetite

M.D. \_\_\_\_\_ Date \_\_\_\_\_

**Barrilleaux / Harrington**

{EBGI Symptoms Review 2 July 2011 Pg . 1/1}

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**CURRENT MEDICATIONS**

All medications, prescription and over-the-counter; *all diet supplements*

Name of Medication	Dose and Frequency	Name of Medication	Dose and Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ALLERGIES**

Name of Medication	Reaction	Name of Medication	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**CURRENT MEDICAL PROBLEMS**

_____	_____
_____	_____
_____	_____
_____	_____

**PROCEDURES**

<u>Check if Applicable</u>	Date	Details
<input type="checkbox"/> Colonoscopy	_____	_____
<input type="checkbox"/> Upper Endoscopy	_____	_____
<input type="checkbox"/> Appendectomy	_____	_____
<input type="checkbox"/> Gallbladder Removal	_____	_____
<input type="checkbox"/> Heart Surgery (Type)	_____	_____
<input type="checkbox"/> Stents	_____	_____
<input type="checkbox"/> Hysterectomy (Partial or Complete)	_____	_____
<input type="checkbox"/> Tubal Ligation	_____	_____
<input type="checkbox"/> Hemorrhoids	_____	_____

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**OTHER SURGERIES**

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**FAMILY HISTORY**

<u>Check if Applicable</u>	Relation	Age
<input type="checkbox"/> Colon Polyps	_____	_____
<input type="checkbox"/> Colon Cancer	_____	_____
<input type="checkbox"/> Other Cancers	_____	_____
<input type="checkbox"/> Ulcers	_____	_____
<input type="checkbox"/> Liver Disease	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____

**SOCIAL HISTORY**

<u>Check if Applicable</u>			
<input type="checkbox"/> Tobacco	# of Packs/Day _____	How Long? _____	Date Quit _____
<input type="checkbox"/> Alcohol	# of Drinks/Week _____	How Long? _____	Date Quit _____
<input type="checkbox"/> Coffee/Tea	# of Drinks/Day _____		
<input type="checkbox"/> Soft Drinks	# of Drinks/Day _____		
<input type="checkbox"/> Regular Exercise	# of Hours/Week _____	Type _____	