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GASTROENTEROLOGY – REVIEW OF SYSTEM

In order to help us provide a thorough evaluation of your digestive problem, please complete this questionnaire. If you desire help completing this form, please speak with the receptionist.

Name _____ Date _____

Part I. Medical History

Please describe your digestive problem: _____

_____

_____

_____

How long have you had this problem and how often does it occur? _____

_____

What seems to help it and what seems to make it worse? _____

_____

Have you had any of the following symptoms?

Fevers weight loss/gain weakness loss of appetite heartburn nausea or vomiting

change of bowel function blood in the stool jaundice difficulty swallowing abdominal pain

fecal soiling other: _____

What medications do you currently take (please include vitamins, hormones, oral contraceptives, over-the counter pills, etc).

_____

_____

Please continue on second page

Please describe your diet, including types of food preferences: _____

Are you allergic to any medications (please specify): _____

Have you had surgery? Please list:

_____

What non-digestive problems do you have? Please list:

_____

Part II. Family History. *What medical problems run in your family? Please fill in family member next to each disease.*

Peptic ulcer _____Diabetes _____Gallbladder disease _____ Crohns disease _____
Heart disease_____ Cancer _____ High blood pressure _____ Ulcerative colitis_____
Other: _____

Part III. Review of Symptoms. *Please Circle Problem Areas*:

General: Loss of appetite Recent weight loss or gain Fevers Weakness Other _____

Skin: Itching Rash Spots Other skin disorder(specify) _____

Ears: Infections Los of hearing **Eyes:** Redness Glaucoma Cataracts Other: _____

Nose: Nosebleeds Sinus infections Hay fever Other (specify) _____

Mouth and Throat: Bleeding gums Sore throats Burning of tongue Hoarseness Other _____

Chest : Cough Breathlessness Asthma Bronchitis Coughing blood Other (specify) _____

Heart: Chest pain High blood pressure Rheumatic fever Heart murmur Other (specify) _____

Urinary: Urgency Incontinence Frequency Blood in urine Infections Kidney stone Other _____

Musculoskeletal: Joint pains Muscle weakness or pain Other (specify) _____

Endocrine: Excess thirst High blood sugar Thyroid disease Goiter Other _____

Neurologic: Stroke Loss of memory Weakness Headaches Seizures Loss of consciousness

Thank you

Jeffrey S. Crespin, MD