ADVANCED DIGESTIVE CARE

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Patient's Name: _____ Today's Date: _____

Reasons for today's visit: _____

Has your overall health changed or have you been diagnosed with any new illness or conditions since your last office visit? If so, please provide details:

_____

_____

Do you need any GI prescriptions refilled at this time? Y☐ N☐

Review of Symptoms

Do you currently have any of these symptoms?

General:
- ☐ Change in general health
- ☐ Change in strength/stamina
- ☐ Fevers/sweats

Endocrine:
- ☐ Unusual change in weight
- ☐ Fatigue/lethargy
- ☐ Change in appetite

Heart and Circulation:
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling in legs

Lungs:
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Neurologic:
- ☐ Headache
- ☐ Poor balance
- ☐ Tingling in fingers/toes

Muscles/ Bones:
- ☐ Joint aches
- ☐ Muscle weakness/pain

Mood:
- ☐ Anxiety/depression
- ☐ Poor sleep
- ☐ Difficulty concentrating

Allergy:
- ☐ Hives/swelling
- ☐ Allergic reaction to medicine

Eyes:
- ☐ Change in vision
- ☐ Eye pain

Ears, Nose, Throat:
- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Sore throat/voice changes

Skin:
- ☐ Rash
- ☐ Discoloration
- ☐ Hair Loss

Genito-Urinary:
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Change in sexual function

Stomach/ Intestines/
- ☐ Nausea
- ☐ Vomiting

Digestion:
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ Bloating/gas
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Belching
- ☐ Rectal bleeding
- ☐ Abnormal bowel sounds
- ☐ Hemorrhoids

Other:
- ☐ _____