Do not write, stamp, punch holes or affix a sticker in this area.
To reproduce, follow the printing instructions.

Direction of Feed

Current Symptoms

Please answer every question

STAFF: Handwritten items must be manually entered.
Do not fold this form.

PLEASE PRINT PATIENT'S LAST NAME

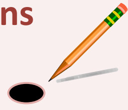
PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month | Day | Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



CURRENTLY ACTIVE SYMPTOMS, TESTS & OTHER CONDITIONS

Mark all that apply. If you have no symptoms in a category, mark NONE.

GENERAL: night sweats ◯ | tiredness ◯ | fever ◯ | lack of appetite ◯ | unintentional weight loss (over 10 lbs) ◯ | NONE ◯

HEAD, EARS, EYES, NOSE & THROAT: wear glasses ◯ | wear contacts ◯ | glaucoma ◯ | hoarseness ◯ | headache ◯ | sleep apnea ◯ | decreased hearing ◯ | NONE ◯

CARDIOVASCULAR: heart stent ◯ | chest pain ◯ | swelling of hands or feet ◯ | elevated blood pressure ◯ | leg cramps ◯ | fainting / blacking out ◯ | NONE ◯

GENITOURINARY: blood in urine ◯ | change in urinary stream ◯ | painful urination ◯ | pelvic pain ◯ | urinary frequency ◯ | NONE ◯

NEUROLOGICAL: dizziness ◯ | fainting ◯ | loss of consciousness ◯ | weakness in extremities ◯ | seizures ◯ | difficult speech ◯ | NONE ◯

ENDOCRINE: cold intolerance ◯ | heat intolerance ◯ | excessive thirst ◯ | excessive urination ◯ | NONE ◯

MUSCULOSKELETAL: backache ◯ | joint stiffness ◯ | physical disability ◯ | NONE ◯

SKIN: itching ◯ | rash ◯ | NONE ◯

RESPIRATORY: chronic cough ◯ | difficulty breathing ◯ | wheezing ◯ | NONE ◯

PSYCHIATRIC: suicidal thoughts ◯ | depression ◯ | anxiety ◯ | NONE ◯

BLOOD: easy bruising ◯ | NONE ◯

BREAST: breast mass ◯ | breast pain ◯ | NONE ◯

GASTROINTESTINAL

nausea ◯	food / milk intolerance ◯	painful swallowing ◯	constipation ◯	heartburn ◯
diarrhea ◯	get full quickly at meals ◯	difficulty swallowing ◯	vomiting blood ◯	belching ◯
bloating ◯	change in bowel habits ◯	stool incontinence ◯	abdominal pain ◯	black stool ◯
vomiting ◯	painful bowel movement ◯	abdominal swelling ◯	blood in stool ◯	laxative use ◯
			gas / flatulence ◯	NONE ◯

Has your stool tested positive for blood in the past 6 months? no ◯ yes ◯

Have you had any of these procedures?

NO	YES	Procedure	Date	Location
◯	◯	**Colonoscopy**	Date: ________	Location: ________
◯	◯	**Flexible Sigmoidoscopy**	Date: ________	Location: ________
◯	◯	**Upper Endoscopy**	Date: ________	Location: ________
◯	◯	**ERCP** (endoscopic retrograde cholangiopancreatography)	Date: ________	Location: ________
◯	◯	**EUS** (endoscopic ultrasound)	Date: ________	Location: ________
◯	◯	**CT scan of abdomen or GI tract** (past 6 months)	Date: ________	Location: ________
◯	◯	**Ultrasound of abdomen or GI tract** (past 6 months)	Date: ________	Location: ________
◯	◯	**Mammogram**	Date: ________	Location: ________
◯	◯	**Pap Smear**	Date: ________	Location: ________
◯	◯	**Recent Laboratory Testing**	Date: ________	Location: ________

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SAMPLE

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