CHIEF COMPLAINTS

_____ Trouble or pain when swallowing
_____ Heartburn
_____ Indigestion
_____ Belching, burping gas
_____ Nausea or vomiting
_____ Loss of appetite
_____ Jaundice (yellow skin)
_____ Weight loss

_____ Pain in stomach or abdomen
_____ Black bowel movements
_____ Constipation
_____ Diarrhea
_____ Blood in bowel movement
_____ Passing gas from rectum
_____ Positive occult blood stool test

1. How long have you had this trouble? __________________________

2. Have you ever had x-rays or tests done for this problem? _____ No _____ Yes

   If so, when and where: __________________________________________

3. Do you have a family history of:

   _____ Hiatal hernia
   _____ Ulcer disease
   _____ Gallbladder disease
   _____ Liver disease
   _____ Pancreas disorders
   _____ Tumors of the colon
   _____ Digestive diseases

4. Have you ever been told you have:

   _____ Inflammatory bowel disease
   _____ TB Exposure
   _____ Hepatitis
   _____ Colitis
   _____ Sexually transmitted disease
   _____ AIDS

5. List any other medical conditions you have: __________________________

6. List any surgeries you have had: __________________________

7. List ALL medications you are presently taking, or have recently finished. (Please include all “over the counter” drugs, including vitamins and aspirin):

   __________________________________________________________________

   __________________________________________________________________

8. Please list any allergies you may have. (Remember to include dye or shellfish allergies):

   __________________________________________________________________

   __________________________________________________________________