FOR INITIAL OFFICE VISIT ONLY

VERMONT
GASTROENTEROLOGY

MEDICATION LIST

PATIENT NAME: _____

DOB: _____

ALLERGIES: _____

MEDICATION	DOSAGE

MEDICAL HISTORY QUESTIONAIRE

PLEASE CIRCLE/FILL IN IF APPROPRIATE:

Constitutional: fever | weight loss | weight gain | loss of appetite

Eyes: eye pain | blurred vision

HENT: frequent canker sores | dental problems

Cardiovascular: chest pain | irregular heart beats

Respiratory: shortness of breath | wheezing | hoarseness

Gastrointestinal: loss of appetite | easy fullness

Heartburn: Yes/No? _____
How long, how often? _____
Does it occur after meals? _____
Does it occur at night? _____

Difficulty Swallowing: Yes/No? _____
Solids/liquids/both? _____
How long, how often? _____

Painful Swallowing: Yes/No? _____
Solids/liquids/both? _____

Nausea: Yes/No? _____
How often? _____
After eating? _____
Before eating? _____
Vomiting? _____

Food intolerance or sensitivity? _____

Abdominal Pain: Yes/No? _____
Location on abdomen? _____
How long, how often? _____
What makes it worse? _____
What makes it better? _____
Is it crampy/achy/sharp? _____
Does the pain radiate? _____
Occur when you eat? _____
Associated with BM? _____
Better with BM? _____

Diarrhea: Yes/No? _____
Watery/loose/mushy? _____
Soon after eating? _____
After certain foods? _____
How long, how often? _____
How many times a day? _____
Occur at night? _____
Is there blood? _____
Is it urgent? _____
Loss of Bowel Control? _____

Constipation: Yes/No? _____

GU: frequent urination | burning on urination |

Skin: rash | new skin lesions |

Neurologic: tingling | numbness

Musculoskeletal: back pain | joint pain | joint swelling

Endocrine: cold intolerance | heat intolerance

Psychiatric: anxiety | depression

FAMILY HISTORY OF ANY OF THE FOLLOWING? If yes, who?

Celiac disease: _____
Crohn's disease: _____
Ulcerative colitis: _____
Colon cancer: _____
Colon polyps: _____