

Digestive Disorders Associates

Thank you for choosing Digestive Disorders Associates to participate in your health care. While our staff is preparing for your visit, please complete these few quick questions as to the reason for today's visit.

Name: _____

Reason for today's visit: _____

Please check off the symptoms below that apply to your current problem.

Allergic/Immunologic	Yes	No
HIV Exposure	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Infections	<input type="checkbox"/>	<input type="checkbox"/>
TB Exposure	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular	Yes	No
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>

Constitutional	Yes	No
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>

Eyes	Yes	No
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Light	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal	Yes	No
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Change in Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>

Hematologic/Lymphatic	Yes	No
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>

Skin	Yes	No
Rashes	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal	Yes	No
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric	Yes	No
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory	Yes	No
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up Blood	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath w exercise	<input type="checkbox"/>	<input type="checkbox"/>

My local pharmacy is: _____

In order to insure that you maintain your medication regime on schedule, please be sure to request any refills that you may need before your next visit.

Medicare	Yes
	No
Appointment Type	Consult
	Follow-Up