Gastro-Intestinal (GI) Medical Questionnaire

Name:_____ Date of Birth:_____ Date:_____

Do you currently suffer from any of these symptoms: Explain when it started, location, what makes it better or worse? Any treatment? If had symptoms in past, explain how long back. Give details.

Are you in good health? Yes No _____
Trouble with excess acid? Yes No Acid reflux? Yes No _____
Excess bloating? Yes No Stomach does not empty for long time after eating? Yes No _____
Abdominal pain or discomfort or cramping: Yes No _____
Excessive gas or flatulence or burping? Yes No Excessive smell or odor? Yes No _____
Nausea or vomiting? Yes No Vomiting blood? Yes No _____
Change in Appetite? Yes No Any reason stress etc? _____
Recent change in weight? Yes No How much gain or loss over what time? _____
Are you trying to lose weight? Yes No What are you doing? _____
Heartburn or Indigestion? Yes No _____
Ulcers Gastric or Duodenal? Yes No GERD? _____
Difficulty swallowing or food gets stuck in throat? Yes No _____
Oral disease: gums, mouth, tongue or throat? Yes No _____
Average # of bowel movements per day? ___ or per week? ___ Recent change in Bowel habits? Yes No
Diarrhea or Loose stools? Yes No _____
Constipation or hard stools? Yes No Irritable Bowel Syndrome (IBS)? Yes No _____
History of Diverticulosis, Diverticulitis, Colitis? Yes No _____
Do you take laxatives, enemas, fiber etc? Yes No How often? _____
Rectal irritation or painful bowel movement? Yes No Hemorrhoids / Fissures? Yes No _____
Black stools or blood in stool? Yes No _____
Gallbladder disease? Yes No Gallbladder surgery? Yes No _____
Hepatitis or Jaundice? Yes No Cancer? Yes No Type? _____
Have you had EGD? Yes No When? Finding? _____History of Barrett's esophagus? Yes No
Have you had Colonoscopy? Yes No When? Finding? _____
Other GI tests? Ultrasound, CT Scan, ERCP? Yes No _____
Do you smoke? Yes No How much & how long?_____
Do you chew tobacco? Yes No How much & how long? _____
How much alcohol do you drink? Per day? _____ or Per week? _____
How much water do you drink? Glasses per day? _____ Size? _____ Total ounces per day? _____
Do you take Enzymes? Yes No Probiotics? Yes No _____
Do you feel tired? Yes No Weakness? Yes No Aches & Pains? Yes No Overall not feeling well? Yes No
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