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. If none, please check "No" box.

Allergic/Immunologic	Yes	No
HIV Exposure		
Persistent Infections		
TB Exposure		

Cardiovascular	Yes	No
Chest Pain		
Palpitations		

Constitutional	Yes	No
Fever		
Loss of Appetite		
Weight Gain		
Weight Loss		

Eyes	Yes	No
Double Vision		
Sensitivity to Light		

Gastrointestinal	Yes	No
Difficulty Swallowing		
Heartburn		
Abdominal Pain		
Abdominal Swelling		
Change in Bowel Habits		
Constipation		
Diarrhea		
Gas		
Jaundice		
Nausea		
Rectal Bleeding		
Stomach Cramps		
Vomiting		
Hemorrhoids		

Hematologic/Lymphatic	Yes	No
Easy Bruising		
Prolonged Bleeding		

Skin	Yes	No
Rashes		

Musculoskeletal	Yes	No
Arthritis		
Muscle Weakness		

Psychiatric	Yes	No
Anxiety		
Depression		
Difficulty Sleeping		
Nervousness		

Respiratory	Yes	No
Cough		
Coughing up Blood		
Shortness of breath w exercise		

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