

WESTSIDE GASTROENTEROLOGY

CONSULTANTS

Circle yes if this is a current symptom you are experiencing unless issue states 'prior'

Patient Name _____

Allergy

Runny nose	yes	no
Hay fever /seasonal allergies	yes	no
Scratchy throat	yes	no
Sinus congestion/pain	yes	no

Cardiology

Dizziness	yes	no
Chest pain	yes	no
Palpitations	yes	no
Leg swelling	yes	no
Shortness of breath	yes	no
Murmurs	yes	no

Constitutional

Weight gain	yes	no
Weight loss	yes	no
Loss of appetite	yes	no
Fever	yes	no
Weakness	yes	no
Fatigue	yes	no
Night sweats	yes	no

Dermatology

Rash	yes	no
Lumps	yes	no
Jaundice yellow skin	yes	no

Endocrinology

Excessive thirst	yes	no
Excessive sweating/flushing	yes	no
Cold intolerance	yes	no
Heat intolerance	yes	no
Diabetes	yes	no
Excessive hunger	yes	no

Ears/Nose/Throat

Nosebleeds	yes	no
Hearing loss	yes	no
Voice changes	yes	no
Sore throat	yes	no

Female Reproductive

Pelvic pain	yes	no
Heavy periods	yes	no
Pain during intercourse	yes	no
Painful menstruation	yes	no
Hot flashes	yes	no
Abnormal vaginal bleeding	yes	no
Irregular periods	yes	no
Prior Sexually Transmitted Disease	yes	no

Gastroenterology

Nausea	yes	no
Vomiting	yes	no
Abdominal pain	yes	no
Heartburn	yes	no
Trouble swallowing	yes	no
Constipation	yes	no
Diarrhea	yes	no
Blood in stool	yes	no
Hemorrhoids	yes	no
Change in bowel habits	yes	no

Hematologic/Lymphatic

Swollen glands	yes	no
Easy bruising	yes	no
Easy bleeding	yes	no
Prior Blood Clot	yes	no

Male Reproductive

Hernia	yes	no
Prior Sexually Transmitted Disease	yes	no

Musculoskeletal

Joint stiffness	yes	no
Joint pain	yes	no

Neurology

Headache	yes	no
Tingling, numbness	yes	no
Seizures	yes	no
Memory loss	yes	no
Gait abnormality	yes	no

Ophthalmology

Eye irritation	yes	no
Eye Pain	yes	no

Psychology

Depression	yes	no
Anxiety	yes	no
High stress level	yes	no
Sleep disturbance	yes	no
Eating disorder	yes	no
Mental, sexual or physical abuse	yes	no

Respiratory

Chest congestion	yes	no
Wheezing	yes	no
Cough	yes	no
Coughing up blood	yes	no
Prior History of Tuberculosis	yes	no

Urology

Difficulty urinating	yes	no
Blood in urine	yes	no
Urinary urgency	yes	no
Urinary incontinence	yes	no
Prior Kidney Stone	yes	no