Date of appointment: _____

Patient name: _____ Date of birth: _____ Age: _____

Primary care provider: _____ Referring provider: _____

Reason for Visit Today (Select all that apply):

☐	Abdominal Distention	☐	Abdominal Pain	☐	Rectal Bleeding	☐	Blood in Stool	☐	Constipation
☐	Diarrhea	☐	Nausea	☐	Rectal Pain	☐	Vomiting	☐	Trouble Swallowing
☐	Incontinence	☐	Heartburn	☐	Acid Reflux (GERD)	☐	Crohn's Disease	☐	Irritable Bowel Syndrome
☐	Inflammatory Bowel Disease	☐	Ulcerative Colitis	☐	Achalasia	☐	Barrett's Esophagus	☐	Eosinophilic esophagitis
☐	Other								

To be filled out by nurse:

Preferred local pharmacy: _____ **Preferred mail order pharmacy:** _____

Preferred laboratory for blood work: _____ **Preferred radiology facility:** _____

HT _____ **Weight** _____ **BP** _____/_____ **Pulse** _____ **Temp** _____

Immunizations: **Flu / When** ☐ / _____ **(65 or older) Pneumovax/When** ☐ / _____

Fallen within the last 3 months? Yes ☐ **No** ☐ **Fear of falling? Yes** ☐ **No** ☐ **Difficulty ambulating? Yes** ☐ **No** ☐

Patient Review of Systems

Please mark any conditions with which you have had symptoms in the last 2 weeks:

	Constitutional
☐	Appetite Change
☐	Fatigue
☐	Fever
☐	Unexpected Weight Change
	HENT
☐	Trouble swallowing
☐	Sore throat
	Eyes
☐	Vision problems
	Respiratory
☐	Apnea
☐	Cough
☐	Shortness of Breath
	Cardiovascular
☐	Irregular Heart Beat
☐	Chest Pain

	Gastrointestinal
☐	Abdominal bloating
☐	Abdominal pain
☐	Rectal Bleeding
☐	Blood in stool
☐	Constipation
☐	Diarrhea
☐	Nausea
☐	Rectal Pain
☐	Vomiting
☐	
	Genitourinary
☐	Painful Urination
	Musculoskeletal
☐	Joint pain
☐	Back Pain
☐	Trouble Walking

	Skin
☐	Skin Color Changes?
☐	Rash?
	Neurological
☐	Light-headedness
☐	Seizures
☐	Headaches
	Hematologic
☐	Swollen Glands
	Behavioral Health
☐	Nervous/Anxious
☐	Sleep Problems

Date of appointment: _____

Date of birth: _____ Age: _____

Patient name: _____

Tobacco Use

Current Everyday smoker	Current Some Day Smoker	Never	Former smoker	Passive Smoker	Heavy Smoker	Light Smoker
☐	☐	☐	☐	☐	☐	☐

Comments on your history with tobacco:

Social History

Alcohol Use

☐ Yes ☐ Not Currently ☐ Never

Drug Use

☐ Yes ☐ Not Currently ☐ Never

Sexually Active

☐ Yes ☐ Not Currently ☐ Never