

GASTROINTESTINAL DISORDERS QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)



1. PATIENT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM / DD / YY	Height <input type="checkbox"/> M <input type="checkbox"/> Ft	Weight <input type="checkbox"/> Kg <input type="checkbox"/> Lb

2. DIAGNOSIS

Please provide details about when the condition was diagnosed:

Date of first visit	Symptoms	
MM / DD / YY	Diagnosis	
Date of last episode	Details	
MM / DD / YY	Symptoms	

Has the patient undergone any of the following tests? If "Yes", please explain. (PLEASE INCLUDE REPORT)

Test		Date	Result
Endoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YY	
Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YY	
Biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YY	
Helicobacter	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YY	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YY	

Treatment

Current condition

Complications

Controls performed

Family history	
Other illnesses	
Other factors <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Coffee	
3. TREATING PHYSICIAN'S INFORMATION	
Name	
Address	
Telephone	
	Fax
Email	
Date	MM / DD / YY
	Signature