Thank you for carefully answering each question!

***Patient:** Blue ink,*
***Doctor:** Red ink*

Patient Name:_____ Date:_____

Gastrointestinal System Health History Form (*Page 1*):

Please answer the following questions as they relate to you, past or present:

1. Do you ever have black, tarry stool? ☐No. ☐Yes, explain?_____.
2. When having a bowel movement do you experience the sensation of not completely emptying? ☐No. ☐Yes
3. Do you ever have pain in your lower abdomen (or tummy) that is relieved by gas or bowel movements? ☐No. ☐Yes
4. Do you ever have alternating constipation and diarrhea? ☐No. ☐Yes.
5. Are your bowel movements ever hard, dry or thin? ☐No. ☐Yes, then are they ☐hard, ☐dry, or ☐thin.
6. Have you ever experienced a "coated tongue" (slight whitish coating in back or middle)? ☐No. ☐Yes
7. Do you experience large amounts of gas? ☐No. ☐Yes, then is it very foul smelling? ☐No, ☐Somewhat, or ☐Very much.
8. Do you have more than 3 bowel movements a day? ☐No. ☐Yes, then how many?_____.
9. Have you noticed red blood in your stool? ☐No. ☐Yes, explain?_____.
10. Do you have to use laxatives frequently? ☐No. ☐Yes, then how often?_____.
11. Are you experiencing excessive belching, burping, or bloating? ☐No. ☐Yes.
12. Do you have gas immediately after a meal? ☐No. ☐Yes.
13. Do you ever experience an offence or foul taste in your mouth? ☐No. ☐Yes.
14. Are you experiencing a sense of fullness during and after meals? ☐No. ☐Yes.
15. Have you noticed undigested food in your stool? ☐No. ☐Yes, describe:_____.
16. Have you noticed burning or aching stomach pain 1 to 4 hours after eating a meal? ☐No. ☐Yes, describe:_____.
17. Do you have to use antacids? ☐No. ☐Yes, how often:_____.
18. Are you still experiencing hunger 1 hr after eating? ☐No. ☐Yes, describe:_____.
19. Do you have heartburn when you lay down or bend forward? ☐No. ☐Yes.
20. Do you have digestive problems that subside with rest and relaxation? ☐No. ☐Yes.
21. Do you get heartburn with spicy foods, chocolate, citrus, peppers, alcohol, or caffeine? ☐No. ☐Yes.
22. Does fiber or roughage in your diet cause constipation? ☐No. ☐Yes.
23. Do you ever experience the sensation of indigestion & fullness lasting 2-4 hrs after eating? ☐No. ☐Yes, how long_____.
24. Do you experience pain, tenderness, or soreness on the left side, under the ribs? ☐No. ☐Yes.
25. Are you having a lot of gas? ☐No. ☐Yes.
26. Do you experience nausea &/or vomiting? ☐No. ☐Yes, & how often_____.
27. Have you observed any undigested food in your stool? ☐No. ☐Yes, then explain:_____.
28. Are you experiencing frequent urinations? ☐No. ☐Yes, then how often?_____.
29. Are you experiencing increased sense of thirst? ☐No. ☐Yes, then how often?_____.
30. Are you experiencing increased hunger? ☐No. ☐Yes, then how often?_____.
31. Are you experiencing difficulty losing weight? ☐No. ☐Yes, then how often?_____.
32. Do you have foul smelling flatulence (gas)? ☐No. ☐Yes, & how often?_____.
33. Have you noticed a greasy appearing stool during your bowel movements? ☐No. ☐Yes, how often?_____.
34. Have you observed your stool to be tan, light brown, or grey? ☐No. ☐Yes, then how often?_____.
35. Does your stool ever float? ☐No. ☐Yes, then how often?_____.
36. Are you having a lot of gas &/or bloating after a meal? ☐No. ☐Yes.
37. Have you noticed a bitter metallic taste in your mouth? ☐No. ☐Yes, then when?_____.
38. Have you observed a yellow color in your eyes? ☐No. ☐Yes.
39. Have you noticed a reddening of your skin? ☐No. ☐Yes, & where?_____.
40. Is you skin dry or flaky? ☐No. ☐Yes, explain_____.
41. Have you ever had gall stones or gallbladder problems? ☐No. ☐Yes, when?_____.

Doctor's Notes:_____

_____

_____

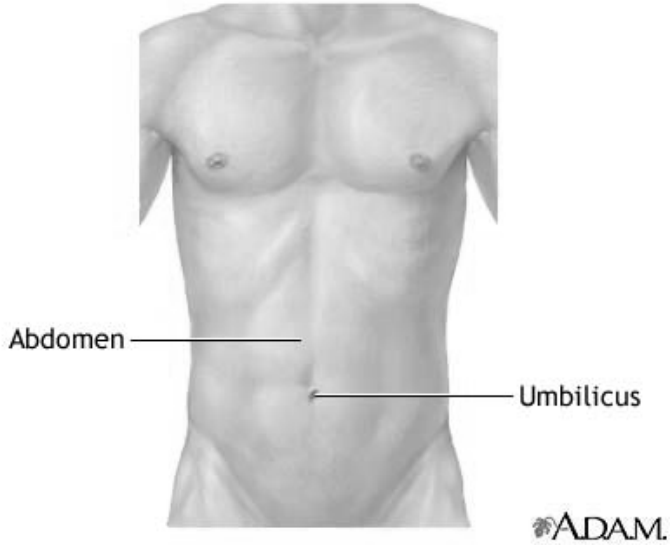
_____

Doctor's Initials:_____

42. Do you have shoulder pain? ☐No. ☐Yes, if yes is it? ☐Right. ☐Left. Also is it? ☐Front of shoulder. ☐Back of shoulder.

Gastrointestinal System Health History Form (*Page 2*):

43. Do you get abdominal pain with bloating, constipation, & diarrhea? ☐No. ☐Yes.
44. Do you have abdominal pain that is relieved with a bowel movement? ☐No. ☐Yes.
45. If yes to #42 or #43, since the pain started have you noticed a change in the frequency of bowel movements? ☐No. ☐Yes.
46. If yes to #42 or #43, since the pain began have you noticed a change in your bowel movement's appearance? ☐No. ☐Yes.
47. Do you have alternating diarrhea & constipation? ☐No. ☐Yes.
48. Do you ever notice mucus in your stool? ☐No. ☐Yes.
49. Do your bowel problems get worse with stress? ☐No. ☐Yes.
50. Do you have pain in your upper abdomen? ☐No. ☐Yes.
51. Do you have heartburn that worsens when lying down? ☐No. ☐Yes.
52. Is your heartburn relieved by sitting up or using antacids? ☐No. ☐Yes.
53. Do you have upper abdomen pain that is relieved by eating or antacids? ☐No. ☐Yes.
54. Have you vomited blood? ☐No. ☐Yes.
55. Has your stool looked black or tarry? ☐No. ☐Yes.
56. Have you been experiencing bloody & watery diarrhea, which is very frequent? ☐No. ☐Yes, how often?_____.
57. Have you noticed weight loss with general fatigue? ☐No. ☐Yes.
58. Have you had cramping diarrhea with occasional bleeding? ☐No. ☐Yes.
59. If you have abdominal pain, please mark on the diagram where the pain is:



Please describe the pain:_____

60. Are you unable to eat? ☐No. ☐Yes.
61. Describe anything unusual you have seen in your stool:_____
62. Describe any unusual recent patterns you have noted with your bowel movements:_____
63. Anything else?_____

Doctor's Notes:_____

Doctor's Initials:_____