



GASTROENTEROLOGY

SPECIALISTS OF OREGON, P.C.

DATE: _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

| | | | | | |
|---|-----------------------------|------------------------------|---|-----------------------------|------------------------------|
| Unexplained Weight Loss | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Difficulty Swallowing | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Poor Appetite | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Regurgitation | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Fever | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Heartburn | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Fatigue | <input type="checkbox"/> No | <input type="checkbox"/> Yes | If yes to heartburn: Occurs at least 2-3x/week? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Blurred Vision | <input type="checkbox"/> No | <input type="checkbox"/> Yes | History frequent heartburn for at least 3-5 yrs? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hearing Loss | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Nausea | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Mouth Sores | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Vomiting | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Chest Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Bloating | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| If yes to chest pain: Has this been evaluated? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Belching | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is it due to heart problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Constipation | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Occurs with exercise? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Diarrhea | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Occurs at rest? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Abdominal Pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Shortness of Breath | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Change in Bowel Habits | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Spitting up Blood | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Rectal Bleeding | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Swelling of Ankles | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Black, Tarry Stools | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Itching | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Headaches | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bleeding Tendency | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Memory Loss | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bruising Tendency | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Depression | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Are you Pregnant? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Anxiety | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you use Tobacco? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Anemia | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| | | | Do you drink alcohol? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

| | | | | | |
|--------------------------|-----------------------------|------------------------------|-------------------|-----------------------------|------------------------------|
| Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Congestive Heart Failure | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Asthma | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Atrial Fibrillation | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Emphysema | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cardiac Pacemaker | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Bleeding Disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cardiac Defibrillator | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Sleep Apnea | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Artificial Heart Valve | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Seizure Disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes |