GASTROENTEROLOGY AND NUTRITION SPECIALISTS

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New Patient Form Name:_____ DOB: _____ Date: _____

What is your main problem?
Date of onset or length of symptoms:_____ If it is pain, how long does it last?: _____
Severity of this problem on a scale of 0 to 10 or state how severe it is to you?: _____
Is it unchanged or worsening? _____
If it is pain. where is it located?_____If moves where does it go? _____
If it is pain, what words would you use to describe it?_____
For this problem, when does it usually occur (i.e.. after meals, with stress, est.)?
What makes it worse?_____
What makes it better? _____
What other symptoms occur at the same time? _____

Colonoscopy and Upper Endoscopy: If performed, give result and year; obtain records if possible.
Radiology study (CAT scan, upper GI, etc): if applicable, result and year; obtain records if possible.
Lab studies (CBC, chemistry, liver profile, etc): obtain records of recent or important results.
Immunizations; State-"Yes" if up-to-date, "No" if never had or not up-to-date, of"?" if unsure:

Hepatitis A___; Hepatitis B___; HPV___; Tetanus___; Influenza in the last year___;
Pneumovax___; Shingles___; TB testing (date of test)___

Allergies (medications/food):_____

Medical problems and medications: example: [diabetes] [Metformin] [500 mg] [2] or [diabetes] [none]

Medical Problem	**Medication*** **	**dose**	**Pills per day**	****or please bring in list****
				Additional Medications/Supplements

Pharmacy telephone number:_____