

# 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 / YYYY	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 / YYYY	Diagnosis	
Date of last episode	Details	
MM / DD / YYYY	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 / YYYY	
Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YYYY	
Biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YYYY	
Helicobacter	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YYYY	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YYYY	

Treatment


Current condition


Complications


Controls performed


Family history
Other illnesses

Other factors  Alcohol  Tobacco  Coffee

### 3. TREATING PHYSICIAN'S INFORMATION

Name			
Address			
Telephone		Fax	
Email			
Date	MM / DD / YYYY	Signature	