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 ☐ M ☐ Ft		Weight ☐ Kg ☐ 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	☐ Yes	☐ No	MM / DD / YYYY	
Colonoscopy	☐ Yes	☐ No	MM / DD / YYYY	
Biopsy	☐ Yes	☐ No	MM / DD / YYYY	
Helicobacter	☐ Yes	☐ No	MM / DD / YYYY	
Other	☐ Yes	☐ 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	

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