OFFICE VISIT HISTORY FORM

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Patient name_____________________________________ Birth date________________ Date ___________

Chief medical complaint:

____

____

Item(s) that you would like to discuss with your doctor:

____

____

____

____

SYMPTOM QUESTIONNAIRE *(complaints during the last **30 days**)*

How ***bad*** are your bowel symptoms?
- ___ None: no symptoms (1)
- ___ Mild: symptoms can be ignored (2)
- ___ Mod: symptoms cannot be ignored (3)
- ___ Severe: symptoms affect your lifestyle (4)
- ___ Very severe: symptoms markedly affect your lifestyle (5)

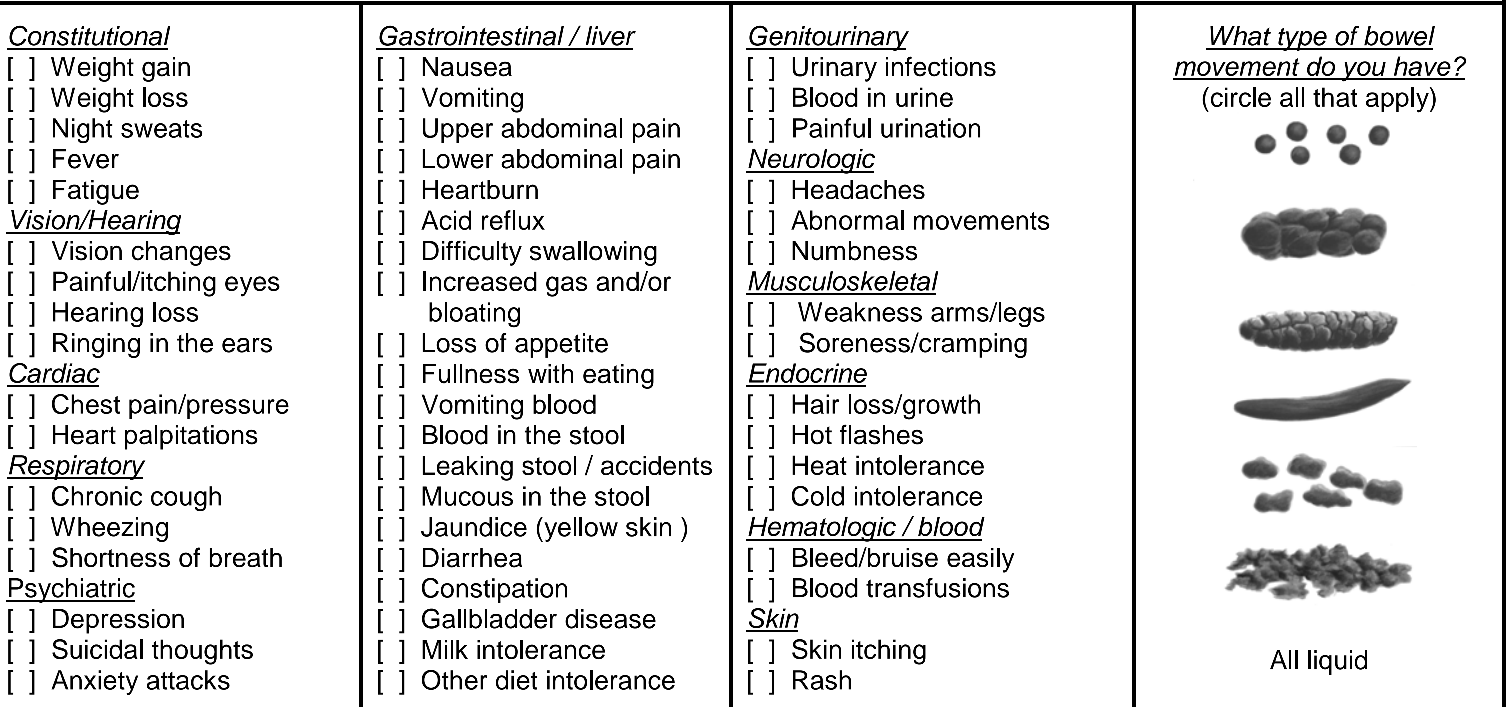
Do you feel ***tense*** or "***wound up***"
- ___ Not at all (1)
- ___ From time to time, occasionally (2)
- ___ A lot of time (3)
- ___ Most of the time (4)

Do you feel like your bowel symptoms mean there's something ***seriously wrong*** with your body?
- ___ No, not at all (1)
- ___ Yes, slightly (2)
- ___ Yes, somewhat (3)
- ___ Yes, quite a bit (4)
- ___ Yes, a great deal (5)

Can you still ***enjoy*** the things you used too?
- ___ Definitely as much (1)
- ___ Not quite as much (2)
- ___ Only a little (3)
- ___ Hardly at all (4)

Score X 2 ____ (0-8 = minimal; 9-17 = mild; 18-26 = moderate; 27-36 = severe)

REVIEW OF SYSTEMS (*complaints during the last **30 days;** check if yes, to all that apply)*



Constitutional
[ ] Weight gain
[ ] Weight loss
[ ] Night sweats
[ ] Fever
[ ] Fatigue

Vision/Hearing
[ ] Vision changes
[ ] Painful/itching eyes
[ ] Hearing loss
[ ] Ringing in the ears

Cardiac
[ ] Chest pain/pressure
[ ] Heart palpitations

Respiratory
[ ] Chronic cough
[ ] Wheezing
[ ] Shortness of breath

Psychiatric
[ ] Depression
[ ] Suicidal thoughts
[ ] Anxiety attacks

Gastrointestinal / liver
[ ] Nausea
[ ] Vomiting
[ ] Upper abdominal pain
[ ] Lower abdominal pain
[ ] Heartburn
[ ] Acid reflux
[ ] Difficulty swallowing
[ ] Increased gas and/or bloating
[ ] Loss of appetite
[ ] Fullness with eating
[ ] Vomiting blood
[ ] Blood in the stool
[ ] Leaking stool / accidents
[ ] Mucous in the stool
[ ] Jaundice (yellow skin)
[ ] Diarrhea
[ ] Constipation
[ ] Gallbladder disease
[ ] Milk intolerance
[ ] Other diet intolerance

Genitourinary
[ ] Urinary infections
[ ] Blood in urine
[ ] Painful urination

Neurologic
[ ] Headaches
[ ] Abnormal movements
[ ] Numbness

Musculoskeletal
[ ] Weakness arms/legs
[ ] Soreness/cramping

Endocrine
[ ] Hair loss/growth
[ ] Hot flashes
[ ] Heat intolerance
[ ] Cold intolerance

Hematologic / blood
[ ] Bleed/bruise easily
[ ] Blood transfusions

Skin
[ ] Skin itching
[ ] Rash

What type of bowel movement do you have?
(circle all that apply)

All liquid

Other ____
____

[ ] Check if all other review of systems are negative

No. stools/day ________
No. stools/week _______

Patient Signature____ Date __________________

MD/NP/PA Signature ____ Date __________________