Comprehensive Gastroenterology

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PLEASE CIRCLE ALL SYMPTOMS
THAT YOU ARE CURRENTLY EXPERIENCING.

Patient Name: _____

DOB: _____ Date: _____

☐ NONE APPLY (Check Box)

General	Loss of Appetite Chills Fatigue Fever Sweats Weight Gain Weight Loss
Eyes	Blurring Discharge Eye Pain Irritation Vision Loss
Ears, Nose, and Throat	Bleeding Gums Hearing Loss Sore Throat Nose Bleeds Nasal Congestion Snoring Earache Ear Discharge
Cardiovascular	Chest Pain Dyspnea on Exertion Loss of Consciousness
Respiratory	Cough Blood in Sputum Wheezing Difficulty Breathing
Female	Abnormal Vaginal Bleeding Blood in Urine Pelvic Pain Frequent/Painful Urination Vaginal Discharge Urinary Incontinence Urinary Urgency Genital Disorders
Male	Frequent/Painful Urination Urinary Incontinence Pelvic Pain Blood in Urine Urinary Urgency Genital Disorders
Musculoskeletal	Arthritis Back Pain Joint Pain Joint Swelling Muscle Weakness
Dermatologic	Dryness Itching Rash
Neurological	Dizziness Headache Paralysis Seizures Tremors
Endocrine	Cold/Hot Intolerance Excessive Thirst
Allergy	Food/Seasonal Allergies Hives Recurrent Infections