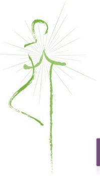

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Digestive Health Form

Name ______________________________ **Date of Visit:**__________________________

So that I may better understand your digestive health issues, please carefully answer the following questions:

Which of these conditions have you had or been diagnosed with? (*Check all that apply)*

a. Constipation _____
b. Diarrhea _____
c. Irritable bowel syndrome (IBS) (diarrhea or constipation predominant) _____
d. Small intestinal bowel overgrowth (SIBO) _____
e. Celiac disease _____
f. Inflammatory bowel disease (that includes Crohn's or ulcerative colitis) _____
g. Diverticulosis or diverticulitis _____
h. Hemorrhoids or anal fissure _____
i. Gastroesophageal reflux disease (GERD) _____
j. Food intolerances _____
k. Any other relevant medical or gastrointestinal history? _____
Explain: ____
____

Do family members have digestive health issues? *(Circle those that apply)* Father Mother Brother(s) Sister (s)

Source of water: Town or well water. If well water, when was it last tested? ______________________

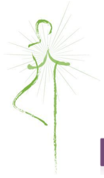
History of food borne illness (food poisoning): ____________________________________
____
____

GI procedures / Testing: Please check the testing you have completed and note any abnormal results or findings:

_____ Colonoscopy: ____
_____ Endoscopy: ____
_____ Gastric emptying test: ____
_____ UGI-small bowel follow through: ____
_____ MRE: ____
_____ Capsule endoscopy: ____
_____ Anal manometry or Defogram: ____

Please check any of the following tests you have had:

Celiac testing by blood test or duodenal biopsy *(circle test)* Y____ N____
Lactose intolerance breath test Y____ N____
Fructose malabsorption breath test Y____ N____
Small intestinal bowel overgrowth (SIBO) test Y____ N____
Were methane and/or hydrogen measured separately? *(circle test)* Y____ N____
Thyroid labs Y____ N____
Vitamin D level *(value if known __________)* Y____ N____
Allergy testing. If so, what type? IgE/Rast test or IgG *(circle test)* Y____ N____



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Supplements: Please check below and specify *type*, *amount,* and *brand* you currently take:
_____ Peppermint oil: ____
_____ Probiotic: ____
_____ HCL/betaine: ____
_____ DGL (deglycyrrhizerd licorice): ____
_____ Zinc: ____
_____ Magnesium *(specify type, i.e., citrate or oxalate):* ____
_____ Vitamin D: ____
_____ Multivitamin: ____
_____ Calcium *(specify type, i.e., citrate or carbonate)*: ____
_____ Iron: ____
_____ Fiber supplements: ____
_____ Laxatives: ____
_____ Other: ____

Gastrointestinal symptoms: On a scale of 1-10 (10 = terrible, 0 = non-existent), please state a number to identify the intensity of the following symptoms:

Gas	1	2	3	4	5	6	7	8	9	10
Bloating	1	2	3	4	5	6	7	8	9	10
Nausea	1	2	3	4	5	6	7	8	9	10
Diarrhea	1	2	3	4	5	6	7	8	9	10
Constipation	1	2	3	4	5	6	7	8	9	10
Abdominal Pain	1	2	3	4	5	6	7	8	9	10
Reflux / GERD	1	2	3	4	5	6	7	8	9	10
Swallowing difficulty	1	2	3	4	5	6	7	8	9	10
Incomplete emptying	1	2	3	4	5	6	7	8	9	10
Fecal incontinence	1	2	3	4	5	6	7	8	9	10

System symptoms:

Skin itch	1	2	3	4	5	6	7	8	9	10
Uticaria (hives)	1	2	3	4	5	6	7	8	9	10
Dry eyes	1	2	3	4	5	6	7	8	9	10
Swollen lips/blistering	1	2	3	4	5	6	7	8	9	10
Atopic dermatitis	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10
Insomnia/sleep disturbance	1	2	3	4	5	6	7	8	9	10
Anxiety	1	2	3	4	5	6	7	8	9	10

Based on the above symptoms, how frequently during the week or month do your symptoms impact your quality of life?

____

Updated: 6.20.18