Digestive Health & History Form

Name: DOB: Age: Male or Female
Primary Care Provider:
Gastroenterologist:
Height: Current Weight: Recent weight loss or gain:

Have you been diagnosed with irritable bowel syndrome?
Yes No
Have you been diagnosed with small intestinal bacterial overgrowth?
Yes No
Have you been diagnosed with celiac disease?
Yes No
Have you been diagnosed with inflammatory bowel disease?
Yes No
Any other relevant medical or gastrointestinal (GI) history?

Relevant Family Medical History:

Source of drinking water: town or well water
If well water, has it been tested recently?
History of foodborne illness?

Please circle any of the following for which you have been tested:
- Celiac testing: was this done by duodenal biopsy or blood test?
- Lactose intolerance breath test
- Fructose malabsorption breath test
- Small intestinal bacterial overgrowth breath test. Were methane and/or hydrogen measured separately?
Yes No Unsure
- Thyroid labs:
- Vitamin D level:
- Allergy testing? If so, what type? IgE/Rast test or IgG

GI Procedures/Testing: *Please circle testing you have completed and note any abnormal results or findings*
-Colonoscopy:
-Endoscopy:
-Gastric empting test:
-UGI-small bowel follow through:
-MRE:
-Capsule endoscopy:
-Anal manometry or Defogram

Medications: List all prescription and over the counter medications

Supplements: *Please circle below and specify type, amount, and brand you are currently taking:*
-Peppermint oil
-Probiotic
-HCL/ betaine
-DGL: deglycyrrhized licorice
-Zinc
-Magnesium {please specify type i.e. citrate, oxalate}
-Vitamin D
-Multivitamin
-Calcium {please specify type i.e. citrate, carbonate}
-Iron {please specify type/brand}
-Fiber supplements:
-Laxatives:
-Other:

Gastrointestinal symptoms:
On a scale of 1-10 (10 = terrible, 0=non-existent) please state a number that identifies the level 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
Dysphagia	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

Systemic 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?

Diet History:
Please provide details about what you might drink and eat in a typical day:

Breakfast:

Lunch:

Dinner:

Snacks:

Do you drink alcohol?
How often? How much?
Do you drink caffeinated beverages such as tea, coffee, and cola?
If so, how much? How often?
Do you struggle finding foods to eat that don't bother your GI symptoms?
Yes No
Have you ever been diagnosed with an eating disorder?
Yes No
If yes, is this still an active issue for you?
Yes No
If yes, do you see a therapist?
Yes No
Do you spend much of your day thinking about food or feel decisions/thoughts around food choices dominate your life?
Yes No
Do you have fears associated with eating?
Yes No
If yes, explain:

What are your primary goals of your nutrition consultation?
1.
2.
3.
4.
5.