



DR JENNIFER L BAILEY

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PATIENT INFORMATION	
NAME:	DATE OF BIRTH:
PHONE NUMBER:	EMAIL:
OCCUPATION:	THIRD PARTY COVERAGE: Y/N

GASTROINTESTINAL SYMPTOMS	<i>Please leave blank for MD</i>
Difficulty swallowing <input type="checkbox"/>	
Heartburn <input type="checkbox"/>	
Indigestion <input type="checkbox"/>	
Nausea/Vomiting <input type="checkbox"/>	
History of ulcers <input type="checkbox"/>	
History of bleeding ulcers <input type="checkbox"/>	
Black tarry stools <input type="checkbox"/>	
Loss of appetite <input type="checkbox"/>	
Feel fuller than normal after a meal <input type="checkbox"/>	
Rectal bleeding <input type="checkbox"/>	
Recent change in bowel movements <input type="checkbox"/>	
Unexplained night time sweats <input type="checkbox"/>	
Unexplained weight loss <input type="checkbox"/>	
History of liver disease <input type="checkbox"/>	

YOUR MEDICAL HISTORY	
High blood pressure <input type="checkbox"/>	
Atrial Fibrillation <input type="checkbox"/>	
Heart disease – previous MI <input type="checkbox"/>	
Asthma <input type="checkbox"/>	
Thyroid disease <input type="checkbox"/>	
Arthritis <input type="checkbox"/>	
COPD/Emphysema <input type="checkbox"/>	
Celiac – Diagnosed by MD <input type="checkbox"/>	
Diabetes <input type="checkbox"/>	
Kidney disease <input type="checkbox"/>	
Genitourinary <input type="checkbox"/>	
Blood Clot – lungs/legs/arms <input type="checkbox"/>	

CURRENT MEDICATIONS	OVER THE COUNTER/HERBAL MEDICATIONS
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11. Blood thinners? <input type="checkbox"/>	11.
12. Advil/Motrin/Aleve? <input type="checkbox"/>	12.

SURGICAL HISTORY	
1.	4.
2.	5.
3.	6.
<p>Have you ever had a colonoscopy, gastroscopy, CT colonography, barium enema or barium swallow? If so, when?</p>	

ALLERGIES
FOOD INTOLELRANCE

SOCIAL HISTORY		
Smoke cigarettes?	<input type="checkbox"/>	<i>If yes, how often a day/week?</i>
Consume alcohol?	<input type="checkbox"/>	
Smoke marijuana?	<input type="checkbox"/>	
Other substance use?	<input type="checkbox"/>	
Coffee	<input type="checkbox"/>	<i>Daily intake?</i>
Tea	<input type="checkbox"/>	
Cola	<input type="checkbox"/>	
Chocolate	<input type="checkbox"/>	
Peppermint	<input type="checkbox"/>	
What is your average snack before bed?		
Average bed time?		
Number of pillows under head at night?		

Are you adopted? Y/N

FAMILY HISTORY		<i>Who? Age at diagnosis</i>
Colon cancer	<input type="checkbox"/>	
Colonic polyps	<input type="checkbox"/>	
Rectal cancer	<input type="checkbox"/>	
Esophageal cancer	<input type="checkbox"/>	
Gastric (stomach) cancer	<input type="checkbox"/>	
Liver cancer	<input type="checkbox"/>	
Gynecologic cancer	<input type="checkbox"/>	
Inflammatory bowel disease (Crohn's/UC)	<input type="checkbox"/>	
Celiac disease	<input type="checkbox"/>	

Height:
Weight:
BMI: