Gastrointestinal Assessment

Date: Patient's Name: Examiner's Name:
Do you have any gastrointestinal concerns or exhibit symptoms of possible gastrointestinal problems?
☐ Yes
□ No
If yes, please describe:
HISTORY
Have you had any changes in appetite or food intake?
☐ Yes
□ No
If yes, please elaborate and mention what you typically eat during a 24-hour period:
Have you had any issues with a change in weight?
Yes
□ No
If yes, please elaborate:
Do you have any difficulty with swallowing liquid or food (dysphagia)? Yes

☐ No

If yes, please elaborate:
Do you have any food intolerance?
☐ Yes
□ No
If yes, which food and what are your reactions to it?
Do you recently have bouts of nausea, vomiting, heartburn, ulcers? — Yes
□ No
If yes, please elaborate:
Please describe your last bowel movement. Are there any changes in your stool? Do you pass gas?
Do you have constipation or diarrhea problems?
☐ Yes
□ No

If yes, has it been a long-term problem? How rarely/often do you have a bowel movement? Please describe your stool.

Please write down any past gastrointestinal disease you were diagnosed with along with the treatment, if applicable.
What medications are you currently taking?
Do you consume alcohol, coffee, cigarettes or recreational drugs? If yes, how often and how many?
INSPECTION NOTES:
AUSCULTATION NOTES:
PALPATION NOTES:

PERCUSSION NOTES:		
OTHER NOTES:		
Patient's Signature:		
Examiner's Signature:		