

# GI Review of Systems

## Patient Information:

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Onset: \_\_\_\_\_

Duration: \_\_\_\_\_

Severity: \_\_\_\_\_

## Dietary History

## Bowel Habits

## Abdominal Pain

Presence: \_\_\_\_\_

Location: \_\_\_\_\_

Intensity: \_\_\_\_\_

Duration: \_\_\_\_\_

## Nausea and Vomiting

Frequency: \_\_\_\_\_

Triggers: \_\_\_\_\_

## Weight Changes

## **Digestive System History**

## **Medication and Allergies**

## **Social and Lifestyle Factors**

## **Review of Systems**

## **Physical Examination**

## **Summary and Recommendations**

## **Follow-up Plan**

## **Patient Education**

## **Provider Signature**

Provider Name: \_\_\_\_\_

Date: \_\_\_\_\_