NW Gastroenterology & Endoscopy
Bellingham, WA

Patient Name: _____ Birth Date: _____

Telephone Number: ( ) _____ email: _____@_____

Address: _____

_____, _____
City, State

Name of your Primary Care Physician: _____

Review Of Systems

Gastrointestinal	Y	N
abdominal pain	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
rectal bleeding	○	○
blood in stool	○	○
heartburn	○	○
regurgitation	○	○
difficulty swallowing	○	○
nausea	○	○
vomiting	○	○

Cardiovascular	Y	N
chest pain	○	○

Respiratory	Y	N
shortness of breath	○	○

Constitutional	Y	N
weight loss more than 5 lbs	○	○
weight gain	○	○
loss of appetite	○	○

Hematologic/Lymphatic	Y	N
bleeding disorder	○	○
clotting disorder	○	○
use of blood-thinning medications besides aspirin	○	○
significant bleeding after a medical procedure	○	○

Allergic/Immunologic	Y	N
unexplained fever	○	○
exposure to or at risk for tuberculosis	○	○

Musculoskeletal	Y	N
joint pain	○	○
trouble walking	○	○

Endocrine	Y	N
heat intolerance	○	○

Genitourinary	Y	N
painful urination	○	○
urinary incontinence	○	○
pregnant or trying to get pregnant	○	○
breastfeeding	○	○
heavy periods	○	○
irregular periods	○	○

Integumentary	Y	N
rashes	○	○

Neurological	Y	N
frequent headaches	○	○
numbness or tingling	○	○
memory loss	○	○
confusion	○	○
implanted device	○	○

Psychiatric	Y	N
sad or depressed feelings	○	○
anxiety attacks	○	○

Eyes	Y	N
significant vision loss or blindness	○	○

ENMT	Y	N
dizziness	○	○

Other recent changes to your health including any recent surgeries? _____

Patient Signature: _____ Date Signed: _____

DO NOT WRITE BELOW THIS LINE: