

MINOR & JAMES MEDICAL



UPPER GASTROINTESTINAL SERIES (UGI) SMALL BOWEL FOLLOW THROUGH (SBFT) ESOPHAGUS/BARIUM SWALLOW (ESO)

Patient:
DOB:
MRN:

Referring Provider:
Date of Service:
Encounter #:

1. Have you ever had an UGI, small bowel or esophagus examination in the past?

Yes No Date: _____ Facility: _____ Results: _____

2. What examinations have you had for the current symptoms or problems?

	Date:	Facility:	Results:
<input type="checkbox"/> Ultrasound	_____	_____	_____
<input type="checkbox"/> CT	_____	_____	_____
<input type="checkbox"/> Endoscopy	_____	_____	_____
<input type="checkbox"/> Colonoscopy	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

3. Please mark all symptoms that apply to today's visit and indicate how long you have had them.

<input type="checkbox"/> Abdominal Pain _____	<input type="checkbox"/> Bloating/Gas _____
<input type="checkbox"/> Indigestion/Heartburn _____	<input type="checkbox"/> Nausea _____
<input type="checkbox"/> Anemia/Bleeding _____	<input type="checkbox"/> Vomiting _____
<input type="checkbox"/> Trouble Swallowing _____	<input type="checkbox"/> Diarrhea _____
<input type="checkbox"/> Other _____	

4. Have you ever had any surgeries in the abdomen, stomach, or esophagus areas?

Yes No Date: _____ Type of Surgery: _____

5. Pre-Menopausal Females:

Is there any possibility of pregnancy? Yes No Date of last menstrual cycle _____