

GI screening form

Patient name _____ Date _____ Date of birth _____

MRN# _____ Ordering physician _____

Please complete the following confidential questions and give to the technologist before your examinations. Your answers will aid the Radiologist, an M.D. who is a specialist in x-ray interpretation, and your own Doctor, to make a more accurate diagnosis of your condition.

The exam you are scheduled for today is _____

What is your chief complaint or reason for having this x-ray? _____

allergies

Please list any allergy you may have below with the reaction you experience or have experienced in the past:

Allergic to

Brief description of your reaction

symptoms

Pain or discomfort (please indicate location on diagram)

Right Left Back Front

Difficulty in swallowing

Discomfort from fried or fatty foods

Nausea or vomiting

Bloody vomiting

Constipation

Diarrhea/Dysentery

Indigestion

Gas or bloating

Yellow Jaundice

Weight loss

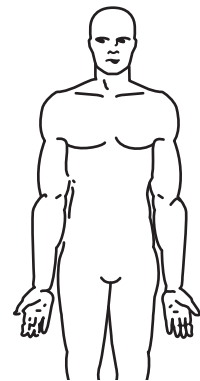
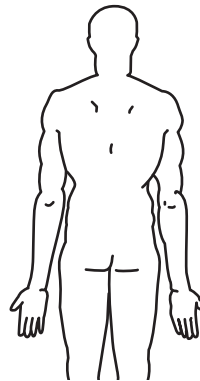
Fever or chills

Blood in stool

Change in bowel habits

BACK

FRONT



Are you an insulin dependent diabetic? Yes No

Do you use Metformin? Yes No

Have you ever had this type of exam before Yes No

When _____ Where _____

Previous surgery? Yes No

When _____ Where _____

Proctoscopy? Yes No

When _____

Biopsy? Yes No

Female patients only Date of last menstrual period _____

Note: Please notify the Technologist if you are pregnant, or if there is a possibility that you may be.

Patient signature _____ Date _____