TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Section I. **Patient** information

1. Last name(s):

2. First name:

3. Middle initial:

4. Date of birth: M M / D D / Y Y Y Y

5. Gender: ◯ Male ◯ Female

6. Height: ◯ Meters ◯ Feet

7. Weight: ◯ Kilos ◯ Pounds

8. Smoker?: ◯ Yes ◯ No

9. Cigarettes per day:

10. Since when?: Y Y Y Y

11. Until when?: Y Y Y Y

Section II. **Symptoms and/or signs** of the illness

1. Start date: M M / Y Y Y Y

2. Acid reflux ◯ Yes ◯ No

3. Diarrhea ◯ Yes ◯ No

4. Abdominal pain ◯ Yes ◯ No

5. Nausea or vomit ◯ Yes ◯ No

6. Blood in the feces ◯ Yes ◯ No

7. Unintentional weight loss ◯ Yes ◯ No

8. Cough ◯ Yes ◯ No

9. Difficulty swallowing ◯ Yes ◯ No

10. Other symptoms or signs ◯ Yes ◯ No

11. Please explain the affirmative answers

Section III. **Diagnosis**

Date of diagnosis M M / D D / Y Y Y Y

Frequency of the consultations

Section IV. **Results of laboratory tests** performed in the last 6 months

1. Date: M M / D D / Y Y Y Y

2. Blood tests:

3. Date: M M / D D / Y Y Y Y

4. Esophagogastroduodenoscopy (EGD):

5. Date: M M / D D / Y Y Y Y

6. Colonoscopy:

7. Date: M M / D D / Y Y Y Y

8. Helicobacter pylori:

9. Date: M M / D D / Y Y Y Y

10. Biopsies:

11. Date: M M / D D / Y Y Y Y

12. Ultrasound:

13. Date: M M / D D / Y Y Y Y

14. Other exams:

Section V. **Treatment**

DIET

Section V. **Treatment** (continued)

MEDICATION 1

1. Name:

2. Since: M M / D D / Y Y Y Y

3. Dose:

4. Until: M M / D D / Y Y Y Y

MEDICATION 2

1. Name:

2. Since: M M / D D / Y Y Y Y

3. Dose:

4. Until: M M / D D / Y Y Y Y

MEDICATION 3

1. Name:

2. Since: M M / D D / Y Y Y Y

3. Dose:

4. Until: M M / D D / Y Y Y Y

SURGICAL PROCEDURES (please indicate details of surgery, date and evolution)

OTHER (explain)

Section VI. **Evolution**

1	Have you ever been hospitalized for a digestive tract disease?	◯ Yes ◯ No
2	Have you had any complications?	◯ Yes ◯ No
3	Do you suffer from any other diseases?	◯ Yes ◯ No
4	Risk factors?	◯ Yes ◯ No
5	Have you consulted any other doctor?	◯ Yes ◯ No

Please explain the affirmative answers:

Section VII. **Attending physician's** information

1. Last name(s):

2. First name:

3. Middle initial:

4. Address:

5. Email address:

6. Office phone: + - -

7. Cellular phone: + - -

8. Signature and seal of the professional:

9. Date: M M / D D / Y Y Y Y

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