BaylorScott&White
CENTER FOR ESOPHAGEAL DISEASES
A member of HealthTexas Provider Network

Patient Name: ___________________________
Patient DOB: ____________________________
Date: ___________________________________

Health History and Symptom Update

Please update us on your health:

Have any other doctors diagnosed a new condition since your last visit?

Please list: ____

Have you had any surgeries since your last visit?

Please list: ____

Has anyone in your family been recently diagnosed with esophageal, stomach, or colon cancer?

Please list: ____

Have there been any other major changes at home or in your life? If so please explain:

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Have you recently experienced any of the following? (Please check all that apply)

- ☐ Trouble Swallowing
- ☐ Food Gets Stuck
- ☐ Choking
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Regurgitation
- ☐ Belching
- ☐ Fevers or chills
- ☐ Fatigue
- ☐ Headaches
- ☐ Dizziness
- ☐ Blurry Vision
- ☐ Double vision
- ☐ Hearing changes
- ☐ Weight Loss
- ☐ Weight gain
- ☐ Change in appetite
- ☐ Feeling full early
- ☐ Sore Throat
- ☐ Voice Hoarseness
- ☐ Congestion
- ☐ Throat Clearing
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Cough
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Yellowing of eyes or skin
- ☐ Skin rashes or lumps
- ☐ Abdominal Bloating
- ☐ Abdominal pain
- ☐ Recent change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black Tar-like stools
- ☐ Bleeding from rectum
- ☐ Vomiting Blood
- ☐ Heat or cold intolerance
- ☐ Trouble with urination
- ☐ Frequency of urination
- ☐ Joint pain or swelling
- ☐ Recent mood changes
- ☐ Memory changes
- ☐ Frequently anxious

Signature: ______________________________ **Date:** ______________