PATIENT DIGESTION EVALUATION

Name: _____ Sex: _____ D.O.B. _____ Date: _____

Patient Health Professional: _____

Height: _____ Weight: _____ Blood Pressure: _____

Circle any of the medications you are taking:

Antacids (Tums, etc.)	Cholesterol Medication	Hormones	Relaxants/Sleeping Pills
Antibiotic/Antifungal	Cortisone Anti-Inflammatories	Laxatives	Recreational Drugs
Antidepressants	Diuretics	Lithium	Specify _____
Antidiebetic/Insulin	Heart Medications	Oral Contraceptives	Thyroid
Aspirin/Tylenol	High Blood Pressure Medications	Radiation	Ulcer Medications
Chemotherapy			Other _____

Circle if you eat, drink, or use:

Alcohol (beer,wine)	Distilled Water	Luncheon Meats	Non-Herbal Teas
Candy	Fluoridated/Chlorinated Water	Margarine	Chews Tobacco
Carbonated Beverages	At fast food restuarants regularly	Refined Sugars	Vitamins & Minerals
Cigarettes	Fried Foods	Milk Products	
Coffee	Refined (White) Flour Products	Artificial Sweeteners	Specify: _____

Circle if you have any of the following:

Gluten Sensitivity
Celiac's Disease
Chinese food or salad bars make you ill?
Do you get hives or headaches from drinking wine?

symptoms within the past year. If you do not understand a symptom, put a ? before the symptom's number.

KEY: **0 = Never** (Occurs once a month of less) **1 = Mild** (Occurs several times monthly) **2 = Moderate** (Aware of it almost constantly) **3 = Severe**

Section A: HCL

1 Bad breath, halitosis……	0	1	2	3
2 Loss of taste for high protein foods (meat, etc.)……..	0	1	2	3
3 Burning ("acid") or nervous stomach, eating relieves……	0	1	2	3
4 Gas shortly after eating……..	0	1	2	3
5 Indigestion 1/2 to 1 hour after eating, may last 3-4 hours……..	0	1	2	3
6 Difficult digesting fruits or vegetables; undigested foods found in stools……..	0	1	2	3
7 Acid or spicy foods upset stomach……..	0	1	2	3
8 I have a dull, achy feeling in my stomach……	0	1	2	3
9 After eating, I get heartburn or acid indigestion……	0	1	2	3
10 Often I have no taste for food, no real appetite……	0	1	2	3

Section B: Liver/Gallbladder

1 Lower bowel gas and/or bloating several hours after eating……..	0	1	2	3
2 Feet burn……	0	1	2	3
3 "Whites" of eyes (sclera) yellow……	0	1	2	3
4 Dry skin, itchy feet and/or skin peels on feet….	0	1	2	3
5 Brown spots or bronzing of skin……	0	1	2	3
6 Bitter metallic taste in mouth……..	0	1	2	3
7 Blurred vision……	0	1	2	3
8 Headache over eyes……	0	1	2	3
9 Feel nauseous, queasy or gag easily……	0	1	2	3
10 Color of stools light brown or yellow……..	0	1	2	3
11 Greasy or high fat foods cause distress……..	0	1	2	3
12 Pain in between shoulder blades……	0	1	2	3
13 Dark circles under eyes……	0	1	2	3
14 "Acid" breath……	0	1	2	3
15 History of gallbladder attacks or gallstones….	0	1	2	3
16 Gallbladder removed……	YES		NO	
17 Appetite reduced……	0	1	2	3
18 Exercise, or physical exertion in general, exhausts me rather than energizes me…….	0	1	2	3

Section C: Colon

1 Coated tongue or "fuzzy" debris on tongue…….	0	1	2	3
2 Pass large amounts of foul smelling gas……	0	1	2	3
3 Irritable bowel, or mucous colitis……	0	1	2	3
4 Constipation, diarrhea alternating or stools alternate from soft to watery……..	0	1	2	3
5 Bowel movements painful or difficult, constipation and/or laxatives used……..	0	1	2	3
6 Burning or itching anus……..	0	1	2	3
7 After eating, I get congested or I get phlegm in my throat……	0	1	2	3
8 Number of bowel movements per day…….	_____			

Additional Digestive Concerns That Are Not Listed: _____