Gastroenterology of the Rockies

Telemedicine Intake Form

1. What is your name?
2. Date of visit?
3. Chief complaint: what is the reason for your visit today?
4. Past medical history
   If there are no changes since your last visit, please check this box: ☐
5. Past surgical history
   If there are no changes since your last visit, please check this box: ☐
6. Medication
   -If there are no changes since your last visit, please check this box: ☐
   -If you have a medication list already saved to your computer please upload this at the time of your visit
   -Remember to add Name, Dose and Frequency of your medication

Medication Name	Dose	Frequency

7. Allergy
   If there are no changes since your last visit, please check this box: ☐

Are you experiencing any of the following symptoms?

GASTROINTESTINAL

Difficulty swallowing (dysphagia):	Yes ☐	No ☐	Belching:	Yes ☐	No ☐
Heartburn:	Yes ☐	No ☐	Abdominal pain:	Yes ☐	No ☐
Nausea:	Yes ☐	No ☐	Flatus:	Yes ☐	No ☐
Vomiting:	Yes ☐	No ☐	Diarrhea:	Yes ☐	No ☐
Bloating:	Yes ☐	No ☐	Constipation:	Yes ☐	No ☐

Are you experience any of the following symptoms? (continued)

GASTROINTESTINAL CONT'D

Rectal pain:	Yes ☐	No ☐	Bright red rectal bleeding (BRRB):	Yes ☐	No ☐
Black tarry stools (melena):	Yes ☐	No ☐	Change in bowel habits:	Yes ☐	No ☐

SKIN

Yellow skin or eyes (jaundice):	Yes ☐	No ☐	Itching:	Yes ☐	No ☐
Rash:	Yes ☐	No ☐			

CARDIOVASCULAR

Chest pain or discomfort:	Yes ☐	No ☐	Palpitation:	Yes ☐	No ☐

RESPIRATORY

Shortness of breath:	Yes ☐	No ☐	Wheezing	Yes ☐	No ☐
Cough:	Yes ☐	No ☐			

GENITOURINARY

Burning sensation during urination:	Yes ☐	No ☐	Frequent urination:	Yes ☐	No ☐
Blood in the urine:	Yes ☐	No ☐			

NEUROLOGIC

Dizziness:	Yes ☐	No ☐	Headache:	Yes ☐	No ☐

ENDOCRINE

Excessive sweating:	Yes ☐	No ☐	Heat intolerance:	Yes ☐	No ☐
Excessive thirst:	Yes ☐	No ☐			

CONSTITUTIONAL

Weight loss:	Yes ☐	No ☐	Fever:	Yes ☐	No ☐
Fatigue:	Yes ☐	No ☐	Loss of appetite:	Yes ☐	No ☐

PSYCHIATRIC

Depression:	Yes ☐	No ☐	Anxiety:	Yes ☐	No ☐

Are you experience any of the following symptoms? (continued)

MALE GENITALIA

Hernia:	Yes ☐	No ☐	Prostate problems:	Yes ☐	No ☐

FEMALE GENITALIA

Severe menstrual pain:	Yes ☐	No ☐	Irregular cycle intervals:	Yes ☐	No ☐

HEMATOLOGIC

Easy bruising:	Yes ☐	No ☐	Blood clot:	Yes ☐	No ☐
Bleeding disorder:	Yes ☐	No ☐			