GASTRO-INTESTINAL QUESTIONNAIRE

Please fax back to IPA at 781 643-2775

NAME: ____DOB: __________________

1. Date first experienced symptoms? ______________________________________
2. Date of last attack and how often do they occur? ___________________________
____
3. Are the attacks becoming more frequent?____________________________________
4. Do you experience any of the below:
   Black stools ____________________ Vomiting ________________
   Relieved by eating _______________ Bleeding ________________
5. Have you had any loss of weight within the past 6 months, if so how much? _____
____
6. Name and address of the physician: _____________________________________
____
____
7. When was the last time consulted with your physician? ____________________
8. How long have you had your illness? ____________________________________
9. What is your actual diagnosis? ____
10. Are you on any medication, if so please explain? ___________________________
____
____
11. Have you had any surgeries for this type of disease, if so please explain? _______
____
____
12. How often do you have a full work up for your intestinal problem? ___________
____
13. What does the complete work up involve? ____________________________
____

Agent Name: ____

Phone Number:________________________Fax No:________________

Date: ___________________ E-mail Address: ________________________

Please circle the associate you work with. Russ, Rhonda, Leo