Today's Date _____

Name: _____ Birth Date: _____

How are you feeling since hospital discharge?

_____
_____
_____

Any changes to your Medical History?

_____

Check all that apply:

___ Abdominal Pain	___ Appetite Poor	___ Bloating	___ Bowel Changes
___ Constipation	___ Diarrhea	___ Gas	___ Heartburn
___ Indigestion	___ Hemorrhoids	___ Nausea	___ Vomiting

___ Difficulty swallowing
___ Pain with swallowing
___ Unintentional weight loss
___ black or red stool

4._____

<u>Medications</u>:

1. (YES / NO) Aspirin
2. (YES / NO) BC Powder
3. (YES / NO) Goody's Powder
4. (YES / NO) Ibuprofen / Motrin
5. (YES / NO) Naproxen / Aleve
6. (YES / NO) Herbal medication
9._____
10._____
11._____
12._____
13._____
14._____

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date Reviewed