

## Gallbladder Health History Form

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

1. Reason for today's visit : \_\_\_\_\_

2. Have you ever experienced any of the following after a meal...

Severe pain or aching in the upper abdomen  Nausea or vomiting

Dull ache beneath the ribs or breastbone  Upset Stomach

Back pain or pain the right shoulder blade  Heartburn

3. Do you get pain after eating a heavy or greasy meal?  Yes  No

4. Do you have a history of Gallstones  Yes  No

5. Have you had images or recent lab work done?  Yes  No

a. If yes please specify when and where: \_\_\_\_\_

6. Any history of dark urine or white colored stools?  Yes  No

7. Jaundice (yellow colored skin or eyes)?  Yes  No

8. Fevers or chills with pain?  Yes  No