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