SUMMIT MEDICAL GROUP

Gastric Emptying Questionnaire

MRN# DOB:

Patient Name: Date:

Provider:

Patient Name: _____ Ordering Provider**:** _____

Reason for today's exam: _____

1. When was the last time you had anything by mouth, including water? _____
2. Are you diabetic? ☐ YES ☐ NO
3. Do you have any food allergies? ☐ YES ☐ NO
   - ☐ If yes, please describe: _____
4. Are you able to tolerate eggs? ☐ YES ☐ NO
5. Have you had any gastric or abdominal surgeries? ☐ YES ☐ NO
   - ☐ If yes, please describe: _____
6. Are you on any medications, specifically drugs such as Reglan or Domperidone? ☐ YES ☐ NO

   If yes, please describe: _____

Female Patients Only:

7. Is there a possibility you are pregnant? ☐ YES ☐ NO

Signature

I have answered all the above questions to the best of my ability.

_____ _____

Patient Signature (or person authorized to sign for Patient) Date

_____

Relationship to Patient if signing for Patient

_____ _____

Interpreter Signature (or ID# if using service), as applicable Date