PRIME HealthCare, PC

GASTROENTEROLOGY

_____

_____

_____

Patient Intake Form

Name: _____ Age: _____ Date of Birth: _____ Date: _____

Height: _____ Weight: _____ Who is your primary doctor? _____ Referring Physician? _____

Reason for seeing a Gastroenterologist: _____

Have you been seen by a doctor in our group ☐ Yes _____ ☐ No
Name of Physician

Were you referred to a specific doctor in our group? Yes No

If yes, (circle) Dr. Zaldonis Dr. Petruff Dr. Jamil Dr. Ayyagari Dr. Corredine

Have you had a __ Colonoscopy or __ Sigmoidoscopy done in the past 10 years? Yes No

If yes, what year was it performed? _____ Were Polyps/Colon Cancer found? Yes No

Who did procedure _____

CURRENT SYMPTOMS: (check all that apply) ☐ None

___ Abdominal pain
___ Nausea
___ Vomiting
___ Bloody vomiting
___ Fevers
___ Chills
___ Loss of appetite
___ Weight loss
___ Change in bowel habits
___ Diarrhea
___ Constipation
___ Rectal bleeding
___ Blood in stool
___ Blood on toilet paper
___ Hemorrhoids
___ Anal pain
___ Black, tarry stool
___ Gas/bloating
___ Heartburn
___ Acid reflux
___ Belching/Burping
___ Indigestion
___ Lactose intolerance
___ Difficulty swallowing
___ Food sticking in esophagus
___ Painful swallowing
___ Jaundice
___ Abnormal liver tests
___ Anemia
___ Stool incontinence

PAST MEDICAL/SURGICAL HISTORY: (check all that apply)

___ None
___ High Blood Pressure
___ Heart Attack/MI
___ Heart Disease/Stents
___ Elevated Cholesterol
___ Heart Valve Problem/Murmur
___ Congestive Heart Failure
___ Atrial Fibrillation
___ Heart Arrhythmia
___ Blood Transfusions
___ Pacemaker/Defibrillator
___ Asthma
___ Lupus
___ Cancer, type(s): _____
___ Emphysema/COPD
___ Lynch Syndrome
___ Tuberculosis
___ Sleep Apnea
___ Lung Clots
___ Diabetes Mellitus
___ Seizure Disorder
___ Stroke/TIA
___ Alzheimer's Disease
___ Parkinson's Disease
___ Thyroid Disease
___ Bleeding Disorder
___ Kidney problems
___ Hemophilia
___ GERD/Acid Reflux
___ Barrett's Esophagus
___ Hiatal Hernia
___ Stomach / Duodenal Ulcer
___ Celiac Disease
___ Helicobacter Pylori
___ Irritable Bowel (IBS)
___ Crohn's Disease
___ Ulcerative Colitis
___ Pancreatitis
___ Hepatitis
___ Hemodialysis
___ Other: _____
___ Fatty liver
___ Diverticulosis
___ Diverticulitis
___ Anemia
___ Depression
___ Anxiety Disorder
___ Bipolar Disorder
___ Schizophrenia
___ Arthritis
___ Osteoporosis
___ Fibromyalgia
___ HIV/AIDS
___ Liver Cirrhosis

PAST SURGICAL HISTORY: (check all that apply)

___ None
___ Coronary bypass
___ Heart valve replacement
___ Pacemaker placement
___ Defibrillator (AICD) placement
___ Removal of gallbladder
___ Removal of appendix
___ Hiatal hernia repair
___ Removal of uterus
___ Removal of ovary/ovaries
___ Tubaligation
___ C-section
___ Prostate surgery
___ Thyroid surgery
___ Lung surgery
___ Gastric bypass surgery
___ Colon surgery
___ Stomach ulcer surgery
___ Inguinal hernia repair
___ Abdominal hernia repair
___ Total knee replacement
___ Total hip replacement
___ Bladder suspension
___ Rectal prolapse surgery
___ Other _____
_____

*** 2 sided form - Please be sure to complete both sides**

Turn Over

PRIME HealthCare, PC

Allergies to Medicine:

Are you allergic to any medication? Yes No Are you allergic to latex? Yes No
If yes, please name medications & reactions: _____
_____

Have you ever had problems with Anesthesia? Yes No

Medications:

Do you take aspirin or arthritis medication (Ibuprofen, Naproxen, Aleve, Motrin, Advil)? Yes No
If yes, please name medication & frequency: _____

Do you take blood thinners (Coumadin, Warfarin, Heparin, Lovenox, Plavix)? Yes No
If yes, please name medication & frequency: _____

Please list other medications you are taking (include "over-the-counter' medicine and doses) ☐ None

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Social History/Martial Status:
___Single ___Married ___ Divorced ___Separated ___Widowed

Circle the number of years of formal education you have completed.
8 9 10 11 12 13 14 15 16 >16

Your occupation: _____ Retired_____ Unemployed_____ Disabled ____

Do you/have you ever used tobacco? ____Yes ___No Packs per day?_____ Years?_____ Date Quit? _____

Do you use chewing tobacco? ____Yes ___No Frequency? _____ Years?_____ Date Quit? _____

Do you drink alcohol? ____Yes ___No ___Beer ___Wine ___Liquor How often?_____ How much? _____

Have you ever used street/illicit drugs? ____Yes ____No Type_____ Last use _____

FAMILY HISTORY
Does anyone in **YOUR FAMILY** have the following illnesses? Check all that apply and write in the relationship of family member, ie. Mother, maternal aunt, paternal uncle, sister.

_____Colon polyps	_____Breast Cancer	_____Skin cancer (ie. Melanoma)	_____Hepatitis
_____Colon cancer	_____Prostate Cancer	_____Liver cancer	_____Bleeding problems
_____Rectal cancer	_____Stomach cancer	_____Pancreatic cancer	_____Ulcerative Colitis
_____Uterine/ Cervical cancer	_____Small bowel cancer	_____Kidney/Ureter cancer	_____Celiac Disease
_____Ovarian Cancer	_____Esophageal cancer	_____Crohn's Disease	_____Gallbladder Disease

Other Cancer (please describe) _____
_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ **Date:** _____

*** 2 sided form - Please be sure to complete both sides**