NEW/RETURN PATIENT INFORMATION

DATE: _____

PATIENT LAST NAME: _____ FIRST: _____ MI: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____ SEX: ____

RACE: _____ ETHNICITY: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: HOME: _____ WORK: _____ CELL: _____

BEST METHOD TO CONTACT YOU – CELL – WORK – HOME – TEXT – OTHER: _____

HOW DO YOU WANT TO RECEIVE YOUR APPOINTMENT REMINDER? TEXT OR CALL

E-MAIL ADDRESS: _____

OCCUPATION: _____ EMPLOYER: _____

SPOUSE NAME: _____ DOB: _____

REFERRED BY: _____

PRIMARY CARE DOCTOR: _____ PHONE: _____ FAX: _____

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP: _____

PHONE: HOME: _____ WORK: _____ CELL: _____

Main Reason for Today's Visit: _____

Current Complaints: (Check any of the following that apply to you)

Difficulty swallowing	___	Painful swallowing	___	Changes in weight	___
Abdominal pain	___	Blood in stool	___	Changes in appetite	___
Constipation	___	Diarrhea	___	Mucous in stool	___
Vomiting	___	Nausea	___	Heartburn	___
Regurgitation	___	Belching	___	Laxative use	___
Fever	___	Bloating	___	Hepatitis C	___
Maroon colored stool	___	Eating disorder	___	Liver enzyme abnormalities	___

Other GI Complaints: _____

Please check the following if they apply to you in the past three months:

	Y	N
General:		
Anorexia	___	___
Fatigue	___	___
Fever/Chills	___	___
Weight Loss	___	___
Skin:		
Pruritis	___	___
Rash	___	___
HEENT:		
Acute Vision Changes	___	___
Earache	___	___
Sore Throat	___	___
Neck:		
Mass	___	___
Swollen Glands	___	___
Respiratory:		
Asthma	___	___
Breathing Problems	___	___
Bronchitis	___	___
Cough	___	___
Dyspnea	___	___
Cardiovascular:		
Chest Pain	___	___
Irregular Heartbeat	___	___
Pacemaker	___	___

	Y	N
Musculoskeletal:		
Back Pain	___	___
Joint Pain	___	___
Neurological:		
Dizziness	___	___
Headaches	___	___
Seizures	___	___
Psychiatric:		
Anxiety	___	___
Changes in Sleep	___	___
Depression	___	___
Endocrine:		
Appetite Changes	___	___
Thyroid Changes	___	___
Any Other Symptoms:	___	___

_____

HISTORY:

Allergies:

Do you have any drug allergies? Yes No

If yes, to what medications and what is the reaction: _____

Do you have allergies to Iodine? Yes No

Do you have allergies to Latex? Yes No

Medications:

Are you taking any medications? Yes No

Please list them along with the dosage and frequency: _____

_____

_____

_____

_____

_____

_____

PHARMACY NAME, City, and Phone Number: _____

Do you take blood thinners (Warfarin, Plavix, or Coumadin, etc.)? Yes No

Do you take Aspirin, Ibuprofen, or similar anti-inflammatory medications on a regular basis? Yes No

If yes to the above two questions, when was your last dose? _____

Have you ever been told that you need antibiotics before any procedure? Yes No

If YES, please notify your physician before your scheduled procedure date

Have you ever had an adverse reaction to Demerol, Versed, pain medication or anesthesia? Yes No

Family:

Does anyone in **<u>your family</u>** have a history of:

	Y	N	Who (Maternal/Paternal)	Age at Onset
Breast Cancer	___	___	_____	
Colon Cancer	___	___	_____	_____
Colon Polyps	___	___	_____	
Endometrial, Uterine or Cervical Cancer	___	___	_____	
Esophageal Cancer	___	___	_____	
Stomach Cancer	___	___	_____	

Personal Past Medical:

Do you have a history of any of the following:

	Y	N			Y	N
Heart conditions	___	___		Kidney Disease	___	___
Heart disease	___	___		Diabetes	___	___
Heart surgery	___	___		Strokes	___	___
Lung or breathing problems	___	___		Glaucoma	___	___
Sleep Apnea/CPAP	___	___		Any Other History	___	___
Hypertension	___	___		Mammogram	___	___
Flu Shot?	___	___	Last	Month/Year _____		
Pneumonia Shot?	___	___	Last	Month/Year _____		
COVID Vaccine	___	___	Moderna/Pfizer/JJ	Month/Year _____		

Please list any prior surgeries – if none please write none: _____

_____

Social:

Do you smoke cigarettes?	Never	Current	Former	How much?	_____
				How many years?	_____
Do you drink alcohol?		Yes	No	How much?	_____
				How many years?	_____
Do you consume caffeine?		Yes	No	How much?	_____
				What type? (Soda/Coffee)	_____
Do you use IV/recreational drugs?		Yes	No	Which Ones?	_____