# New Patient Form

Patient History Worksheet: Page 1

Please bring this completed form to your appointment and be prepared to answer these questions.

Name_________________________________ Date of Birth_______________

Reason for appointment: ____________________________________________

## PATIENT INFORMATION

**Ethnicity:**

☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to Specify ☐ Prohibited by State Law ☐ Unknown

**Race:**

☐ White ☐ African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other Race ☐ Unknown ☐ Decline to Specify ☐ Prohibited by State Law

**Sex:**

☐ Female ☐ Male ☐ Other ☐ Unknown

**Preferred Language:**

☐ English ☐ Decline to Specify

## MEDICAL HISTORY

I consent to the obtaining a history of my medications purchased at pharmacies

☐ Yes ☐ No

**Allergies:** (list all medication, food, IV Dye or latex):

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Current Medications:** (prescription, over the counter, vitamins—list name and dosage)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Immunizations:**

☐ None

☐ Pneumonia When:__________ ☐ Up to date

☐ Influenza When:____________ ☐ Up to date

☐ Hep A When:__________ ☐ Up to date

☐ Hep B When:__________ ☐ Up to date

☐ Shingles When:_________ ☐ Up to date

☐ SARS-CoV-2(COVID) When:____________ ☐ Up to date

**Diagnostic Studies / Tests:**

☐ None

☐ Colonoscopy When:__________

☐ EGD When:____________

☐ EUS When:__________

☐ ERCP When:__________

☐ Sigmoidoscopy When:_________

☐ Capsule Endoscopy When:__________

☐ PEG tube placement When:____________

☐ EGD / Dilation When:__________

**Please Continue On Other Side**

# New Patient Form

Patient History Worksheet: Page 2

Name________________________________ Date of Birth_______________

## PAST OR PRESENT MEDICAL CONDITIONS

### Gastrointestinal:

- ☐ Acid Reflux/GERD
- ☐ Alcohol Abuse
- ☐ Anal Fissure
- ☐ Barrett's Esophagus
- ☐ Bowel Obstruction
- ☐ C. Diff
- ☐ Duodenal Ulcer
- ☐ Crohn's Disease
- ☐ Chronic
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Colon Cancer
- ☐ Constipation
- ☐ Diverticulosis
- ☐ Celiac Disease or Spruce
- ☐ Colon Polyps
- ☐ Diverticulitis
- ☐ Kidney Disease
- ☐ Liver Cancer
- ☐ Esophageal Structure or Narrowing
- ☐ Esophageal Varices
- ☐ Colitis / Ulcerative
- ☐ Eating Disorder
- ☐ Helicobacter Pylori Infection
- ☐ Hemorrhoids
- ☐ Gallbladder Problems
- ☐ Gastrointestinal Bleeding
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Intestinal Infection
- ☐ Stomach Ulcer
- ☐ Liver Failure
- ☐ Pancreatitis

### Current Gastrointestinal Complaints:

- ☐ Heartburn
- ☐ Indigestion
- ☐ Regurgitation
- ☐ Nausea
- ☐ Vomiting
- ☐ Lactose/Food Intolerance
- ☐ Rectal Bleeding
- ☐ Blood On Stool/Toilet Paper
- ☐ Rectal Pain
- ☐ Abdominal Pain
- ☐ Difficulty Swallowing
- ☐ Abnormal Weight Loss
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Leaking Stools
- ☐ Jaundice (yellow skin/eyes)
- ☐ Loss of Appetite

### Other Medical Conditions:

- ☐ Anemia
- ☐ Arthritis
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ ADD
- ☐ Breast cancer
- ☐ Cancer
- ☐ Physical or sexual abuse
- ☐ Gall stones
- ☐ Chronic renal failure
- ☐ Alzheimer's
- ☐ Autoimmune Disease
- ☐ Dialysis
- ☐ Sleep Apnea
- ☐ Congestive Heart Failure
- ☐ COPD (emphysema)
- ☐ Heart Disease
- ☐ Implanted devices
- ☐ High blood pressure
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ HIV positive
- ☐ Depression
- ☐ Mental illness
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Dementia
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Hiatal Hernia
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypertrigylceridemia
- ☐ Hypothyroidism
- ☐ Dialysis
- ☐ Mouth / throat cancer
- ☐ Kidney stones
- ☐ Blood cancer
- ☐ Liver disease
- ☐ Lung cancer
- ☐ Migraine headache
- ☐ Heart attack (MI)
- ☐ Obesity
- ☐ Osteopenia
- ☐ Parkinson's disease
- ☐ Stomach ulcers
- ☐ Prostate cancer
- ☐ Prostate hyperplasia, benign
- ☐ Seizure disorder
- ☐ Sleep apnea
- ☐ Thyroid disease
- ☐ Valvular heart disease
- ☐ Muscle disease
- ☐ Cataracts
- ☐ Tooth enamel problems
- ☐ Cystic fibrosis
- ☐ Autism
- ☐ Blindness

### Previous Procedures:

| Procedure | YEAR |
|---|---|
| AAA repair | ______ |
| Angioplasty | ______ |
| Aortic Valve Replacement | ______ |
| AP Resection | ______ |
| Appendix | ______ |
| Back surgery | ______ |
| Bronchoscopy | ______ |
| Cataract surgery | ______ |
| CABG (heart bypass) | ______ |
| Carpal tunnel release | ______ |
| Cesarean section | ______ |
| Gall Bladder | ______ |

| Procedure | YEAR |
|---|---|
| Colon Resection | ______ |
| Colostomy | ______ |
| Coronary Stent | ______ |
| Gastric bypass | ______ |
| Hartmann procedure | ______ |
| Hemorrhoidectomy | ______ |
| Hernia repair | ______ |
| Hip replacement | ______ |
| Hip replacement | ______ |
| Knee replacement | ______ |
| Liver biopsy | ______ |
| Lysis of adhesions | ______ |

| Procedure | YEAR |
|---|---|
| Mastectomy | ______ |
| Mitral valve replacement | ______ |
| Nephrectomy | ______ |
| Pacemaker/IACD | ______ |
| Prostate biopsy | ______ |
| Rotator cuff repair | ______ |
| Small bowel resection | ______ |
| Hysterectomy & ovaries | ______ |
| TURP | ______ |
| Thyroidectomy | ______ |
| Vaginal hysterectomy | ______ |

**Please Continue On Other Side**

# New Patient Form

Patient History Worksheet: Page 3

Name________________________________________ Date of Birth__________________

**Past Colonoscopy History:**

Date: __________________ Facility: ________________________________ Results: ____________________

**Family History**:

| | Mother | Father | Sister | Brother | Daughter | Other |
|---|---|---|---|---|---|---|
| Colon Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Crohn's Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stomach Problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Celiac Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colon Polyps | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Liver Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ulcerative Colitis / IBD | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Social History**:

Tobacco Use:

☐ Never ☐ Former ☐ Current (how much)______________________

Alcohol Use:

☐ None ☐ Occasional ☐ Moderate ☐ Heavy ☐ Former

Drug Use:

☐ None ☐ Recreational drugs ☐ IV drugs currently ☐ IV drugs in past

**Preferred Pharmacy:** ________________________________________________________________________

**Other Information:** __________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**Consent To Share:**

I consent to having my medical and demographic information used and disclosed to provide my care and treatment, to bill and collect payment for the services provided, and to perform necessary routine office operations.

☐ YES ☐ NO

Signature__________________________________________________________ Date________________________

**INTERNAL USE ONLY: (Reviewed with, not shown in portal):**

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

**Thank you for providing this information.**