

PATIENT INFORMATION:

Date_____

Name_____Date of birth_____

Address_____Age_____

City_____State_____Zip_____

Telephone (Home)_____ (Work)_____ (Cell phone #)_____

E-mail_____Marital Status S M W D Gender M F

Patient's Social Security Number_____

Primary Physician_____Referring Physician_____

Other doctors involved in your care_____

In Case of Emergency, Contact:_____Phone #_____

Employer's Name_____Occupation_____

Employer's Address_____

INSURANCE INFORMATION

Primary Insurance_____

Claim Address_____

Policy Holder's Name_____Policy Holder's Date of Birth_____

Subscriber's ID#_____Group#_____

Secondary Insurance_____

Claim Address_____

Policy Holder's Name_____Policy Holder's Date of Birth_____

Subscriber ID#_____Group#_____

I hereby assign all medical and surgical benefits including Medicare, Private Insurance and other plans to Gastroenterology Associates of Northern New York , PC. I give authorization for record release to anyone necessary for billing or the continuation of my care for diagnosis and treatment.

Patient Signature_____ **Date**_____

I hereby give permission to leave a message on my voicemail concerning my personal health information. I further understand that this permission to communicate my personal health information will be in effect until I request, in writing, to have this option terminated.

Patient Signature_____ **Date**_____

Five Irongate Center, Glens Falls, NY 12801
CONFIDENTIAL HEALTH HISTORY

Welcome to our practice. In order to help provide the best possible gastrointestinal consultation, please complete this form prior to your upcoming visit.

Patient Name _____ Birthdate _____ Date _____

Referring Physician _____ Age _____

Other Physicians involved in your care _____

Describe your main GI problem: _____

Past Medical History

Have you ever had the following: (circle "no" or "yes", leave blank if uncertain)

AIDS or HIV.....	no yes	Diverticulosis/Diverticulitis	no yes	Liver Disease.....	no yes
Anemia.....	no yes	Emotional illness.....	no yes	Migraines.....	no yes
Arthritis.....	no yes	Esophageal Reflux.....	no yes	Pancreatic Disorder...	no yes
Asthma.....	no yes	Gallstones.....	no yes	Seizure Disorder.....	no yes
Bleeding		Glaucoma.....	no yes	Sleep Apnea.....	no yes
Tendency.....	no yes	Heart Disease	no yes	Thyroid Disease	no yes
Blood		Heart Murmur	no yes	Turberculosis	no yes
Transfusion...	no yes	Heart Valve Replacement	no yes	Ulcer.....	no yes
Cancer	no yes	Hemorrhoids.....	no yes	Ulcerative Colitis.....	no yes
Celiac Disease		Hepatitis.....	no yes		
(Sprue)	no yes	Hernia.....	no yes		
Colon Cancer...	no yes	High Blood Pressure.....	no yes		
Colon Polyps.....	no yes	IBS (Irritable Bowel			
Crohn's Disease..	no yes	Syndrome).....	no yes		
Diabetes.....	no yes	Kidney Disease.....	no yes		

Any other health problems _____

Previous Surgeries/Serious Illnesses Requiring Hospitalization	When?	Hospital/City/State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous GI Evaluation (eg. colonoscopy, endoscopy, CT scan, etc.) No ___ Yes ___
(If yes, please list specific exams performed, the findings, and the date of the exam)

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms		Gastrointestinal		Neurologic	
Good General Health Lately	no yes	Nausea	no yes	Headaches	no yes
Recent weight gain	no yes	Vomiting	no yes	Tremors	no yes
Recent Weight loss	no yes	Change in bowel movements	no yes	Paralysis	no yes
Fatigue	no yes	Black tarry stools	no yes	Head injury	no yes
		Frequent diarrhea	no yes	Lightheaded or dizzy	no yes
		Constipation	no yes	Convulsions or seizures	no yes
Eyes		Rectal Bleeding	no yes		
Eye disease or injury	no yes	Abdominal Pain	no yes	Psychiatric	
Cataracts	no yes	Loss of appetite	no yes	Memory loss or confusion	no yes
Blurred or double vision	no yes	Heartburn	no yes	Nervousness/anxiety	no yes
		Swallowing difficulties	no yes	Depression	no yes
Ears/Nose/Mouth/Throat		Bloating	no yes	Insomnia	no yes
Hearing loss or ringing	no yes	Dairy product intolerance	no yes		
Chronic sinus problems	no yes	Fatty food intolerance	no yes	Endocrine	
Nose Bleeds	no yes			Thyroid Problems	no yes
Mouth Sores	no yes	Genitourinary		Heat or cold intolerance	no yes
Swollen glands in neck	no yes	Frequent urination	no yes	Skin becoming dryer	no yes
Hoarseness	no yes	Burning or painful urination	no yes		
		Blood/air in urine	no yes	Hematologic/Lymphatic	
		Incontinence or dribbling	no yes	Bleeding or bruising	
Cardiovascular		Kidney stones	no yes	tendency	no yes
Chest pain or angina pectoris	no yes	Are you pregnant now	no yes	Phlebitis	no yes
Palpitations	no yes	Heavy Periods	no yes		
Shortness of breath	no yes			Integumentary (skin)	
Swelling of feet, ankles	no yes	Musculoskeletal		Rash or itching	no yes
		Joint Pain	no yes	Jaundice	no yes
Respiratory		Stiffness or swelling	no yes	Tattoos	no yes
Chronic cough	no yes	Muscle Cramps, weakness	no yes	Change in hair or nails	no yes
Spitting up blood	no yes	Back Pain	no yes		
Wheezing	no yes	Cold extremities	no yes	Other	
Use oxygen at home	no yes	Difficulty in walking	no yes	_____	
Sleep Apnea	no yes			_____	
CPAP or BiCAP at home	no yes			_____	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient, Parent, or Guardian Date _____
Signature of Physician Date

