



PATIENT NAME: _____

Have you undergone recent diagnostic testing within the last six months? (Please circle)

- | | |
|--------------------------|----------|
| 1. CT Scan | YES / NO |
| 2. MRI | YES / NO |
| 3. Bloodwork | YES / NO |
| 4. Upper GI Series | YES / NO |
| 5. Barium Enema | YES / NO |
| 6. Ultrasound | YES / NO |
| 7. Colonoscopy | YES / NO |
| 8. Upper Endoscopy (EGD) | YES / NO |
| 9. Other Testing | YES / NO |

If you have answered YES to any of the above, please bring paper copies of all reports on the day of your visit.

Thank you.

Name: _____

Date of Birth: _____

Do any of the following currently apply? Please circle all that apply.

Fever / chills / fatigue / sleep disturbance / change in appetite / weight gain / weight loss / headache / mouth ulcers

Hearing impairment / ringing in the ears / sinus pain / swollen glands

Double vision / blurred vision / eye pain / history of eye inflammatory disorders

Chest pain / irregular heart beat / fluid accumulation in the legs

Abdominal pain / heartburn / difficulty swallowing / painful swallowing / nausea / vomiting / change in bowel habit / constipation / diarrhea / rectal bleeding / dark stools / intolerance to dairy

Heavy menstrual bleeding / menstrual bleeding between periods

Burning on urination / difficulty with urination / blood in urine

Muscle aches / painful joints / swollen joints

Hives / rash / itching / seasonal allergies / food allergies

Dizziness / fainting / memory loss / seizures

Anxiety / depressed mood / mood swings / irritability / substance abuse / are you a victim of physical or mental abuse

Do you have any drug allergies? YES / NO

If so, what medicine(s) are you allergic to *and* what is the reaction?

Do you use anti-inflammatory drugs (Ibuprofen, Advil, Aleve, ect.)? YES / NO - How Much? _____

Do you use? – Aspirin, Vitamin E, Coumadin (Warfarin), Plavix (Clopidogrel), Pradaxa (Davigatran), Xarelto (Rivaraxaban), Pletal (Cilostazol), Effient (Prasugrel), Brilinta (Ticagrelor), Ticlid (Ticlopidine), Eliquis (Apixaban)

Please list all medications and dosages (include over the counter drugs, vitamins and supplements)

1.

4.

7.

2.

5.

8.

3.

6.

9.

Name: _____ Date of Birth: _____

Medical History – *Have you ever been diagnosed with any of the following? Please check all that apply.*

- | | |
|--|---|
| <input type="checkbox"/> Abdominal aortic aneurysm (I71.4) | <input type="checkbox"/> Glaucoma (H40.9) |
| <input type="checkbox"/> Anemia (D64.9) | <input type="checkbox"/> Heart Attack (I21.3) |
| <input type="checkbox"/> Arthritis (M19.90) | <input type="checkbox"/> Hemorrhoids (K64.9) |
| <input type="checkbox"/> Arthritis, Rheumatoid | <input type="checkbox"/> Hepatitis (K75.9) |
| <input type="checkbox"/> Asthma (J45.9_ _) | <input type="checkbox"/> Hepatitis B (B19.10) |
| <input type="checkbox"/> Atrial Fibrillation (I48.91) | <input type="checkbox"/> Hepatitis C (B19.20) |
| <input type="checkbox"/> Bladder Infection (N30.90) | <input type="checkbox"/> Hepatitis due to alcohol (K70.10) |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Hiatal Hernia (K44.9) |
| <input type="checkbox"/> Chemotherapy, currently | <input type="checkbox"/> High Blood Pressure (I10) |
| <input type="checkbox"/> Breast Cancer, history (Z85.3) | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Colon polyps, personal history (Z86.010) | <input type="checkbox"/> Intestinal Bleeding (K92.2) |
| <input type="checkbox"/> Colon cancer, personal history (Z85.038) | <input type="checkbox"/> Irritable Bowel Syndrome (K58.9) |
| <input type="checkbox"/> Celiac Disease (K90.0) | <input type="checkbox"/> Kidney Disease (N18.3) |
| <input type="checkbox"/> Cirrhosis (K74.60) | <input type="checkbox"/> Kidney Infection (N15.9) |
| <input type="checkbox"/> Coronary Artery Disease (I25.10) | <input type="checkbox"/> Kidney Stone (N20.0) |
| <input type="checkbox"/> Crohn's Disease (K50.90) | <input type="checkbox"/> Lyme Disease (A69.20) |
| <input type="checkbox"/> Diabetes (E11.9) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diverticulosis (K57.90) | <input type="checkbox"/> Pancreatitis (K85.9) |
| <input type="checkbox"/> Elevated Cholesterol (E78.0) | <input type="checkbox"/> Peptic Ulcer (K27.3) |
| <input type="checkbox"/> Emphysema (J43.9) | <input type="checkbox"/> Radiation Therapy, current or past |
| <input type="checkbox"/> Endocarditis (Infected Heart Valve) (I38) | <input type="checkbox"/> Sleep Apnea (G47.30) |
| <input type="checkbox"/> Endometriosis (N80.9) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fibromyalgia (M79.7) | <input type="checkbox"/> Thyroid, overactive (E05.90) |
| <input type="checkbox"/> Gallstones (K80.20) | <input type="checkbox"/> Thyroid, underactive (E03.9) |
| <input type="checkbox"/> Gastritis (K29.70) | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> GERD – Gastroesophageal Reflux (K21) | |

Do you have a personal history of any of the following: YES/NO

Colorectal, Gastric, Endometrial, Pancreatic or Ovarian Cancer? (Please circle) What age? _____

Surgical History: *Have you had any of the following surgeries? Please check all that apply and indicate what year.*

Family History: *Do you have a family history of any of the following?*

- Aneurysm repair
 - Appendectomy
 - Back surgery
 - Blood transfusion prior to 1992
 - Coronary artery bypass surgery
 - C-Section
 - Cancer operation
 - Cardiac pacemaker placement
 - Carotid artery surgery
 - Colon surgery
 - Gall bladder surgery
 - Heart valve replacement
Which valve? _____
 - Hernia repair
 - Hysterectomy
 - Implanted cardiac defibrillator
 - Joint replacement
Which joint? _____
 - Ovary removal
 - Prostate surgery
 - Thyroid surgery
 - Weight loss surgery
- In past colonoscopies, have you had 10 or more polyps? YES / NO
- Where was your last colonoscopy performed? When?

- YES / NO Colon or Rectal Cancer
Which relative? _____
- YES / NO Crohn's Disease or Ulcerative Colitis
Which relative? _____
- YES / NO Alcoholism
Which relative? _____
- YES / NO Celiac Disease
Which relative? _____
- YES / NO Were you or your mother born outside the United States?
Where? _____
- Mother: Alive / Deceased (Please circle)
Please list medical problems or cause of death
- Father: Alive / Deceased (Please circle)
Please list medical problems or cause of death
- Siblings:
- Have any family members been diagnosed with any of the following? YES / NO
- Colorectal, Gastric, Endometrial, Pancreatic or Ovarian Cancer?
(Please circle)
- What family member(s) and what ages? _____

Social Habits:

- YES / NO Tobacco Use How much per day? _____ If previous, when did you quit? _____
- YES / NO Alcohol Use How much per week? _____ If previous, when did you quit? _____
- YES / NO Recreational Drug Use Which drug(s)? _____ If previous, when did you quit? _____

MAIN LINE GASTROENTEROLOGY ASSOCIATES, P.C.

Patient Information Record

Please **PRINT** all information.

Date _____

Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ Social Security # _____

Employer _____ Occupation _____

Circle One: Sex M F Marital Status: S M W D Age _____ Date of Birth _____

Circle One – Ethnicity: Hispanic or Latino Not Hispanic or Latino Race _____ Language _____

Spouse's Name _____ Spouse's Work Phone _____

Spouse's Employer _____

Emergency Contact (other than spouse) _____ Relationship _____

Emergency Contact Phone _____

Family Doctor _____ Phone _____

List other doctors seen regularly _____ Phone _____

_____ Phone _____

Who recommended that you consult a gastroenterologist?

() Family Doctor (above)

() Another Physician _____ Phone _____

() Other _____

INSURANCE INFORMATION

Insurance company and address _____

Name of Policyholder _____ Group# _____

Policy/ID# _____ Medicare# _____

Policyholder employer _____ Policyholder Date of Birth _____

CONSENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I understand and agree that Main Line Gastroenterology Associates may provide treatment to me and may use and disclose protected health information about me for treatment, payment and/or health care operations. I authorize payment of medical benefits on my behalf to Main Line Gastroenterology Associates for services received. I also authorize the release of any medical or other information necessary to process my claims.

SIGNED: _____ **DATE:** _____

DO NOT MAIL THIS FORM

Reviewed for accuracy: _____

Name of Patient (Please Print)

Date of Birth

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I received the Notice of Privacy Practices for Main Line Gastroenterology Associates, P.C. and Main Line Endoscopy Center, LLC.

Main Line Gastroenterology Associates' electronic record system is accessible to external health providers such as Main Line Health. If you do not want your MLGA records accessible to other physicians or hospitals, please let our staff know.

I request that you attempt to contact me with confidential communications about my health care in the following way(s):

Leave a message on home answering machine? Yes No, Phone#: _____

Leave a message on voicemail at place of employment? Yes No, Work#: _____

Leave a message on cell phone? Yes No, Cell#: _____

Online Patient Portal? Yes No, Email _____

Discuss my healthcare with family members? (Please specify)

Additional Instructions _____

PLEASE NOTE IT IS THE PATIENT'S RESPONSIBILITY TO CALL FOR ANY TEST RESULTS.

*****This request will remain in effect unless otherwise revoked in writing*****

Signature of Patient or Personal Representative

Date

Print Name of Personal Representative

Relationship to Patient