GASTROENTEROLOGY ASSOCIATES of ROCHESTER, LLP
2440 Ridgeway Avenue Rochester, NY 14626
Medical Intake Form

Name____ **Date of Birth**_________________________________

Primary Care Physician _______________________________**OB/GYN if applicable** __________________________

Have you ever had a Colonoscopy/Gastroscopy in the past? ______**When** _________ **Where**________________________

Current complaints/symptoms:____

Hospitalizations/Surgeries (what & when) ____

____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

☐ Diabetes	☐ Colon polyps	☐ Stomach ulcers	☐ Substance abuse
☐ A pacemaker/defibrillator	☐ Lung Disease/home oxygen use	☐ Dialysis Shunt	☐ Organ Transplant
☐ Hx of Cancer (Type _______)	☐ Liver Disease	☐ Artificial heart valve	☐ Immune Problem
☐ Hepatitis	☐ Heart valve problem	☐ Anxiety	☐ Depression
☐ Kidney disease	☐ Seizure disorder	☐ High cholesterol	☐ High Blood Pressure
☐ Heart disease _________	☐ Stroke	☐ Thyroid Problems	☐ Arthritis
☐ Asthma	☐ Bleeding tendencies	☐ Other________________	

Are you taking any medications? No / Yes **If yes, attach a current medication list including dosages.**

Allergies to medicines/latex? No / Yes Please list with reaction ____

____

Do you have any history of problems with anesthesia/sedation? □ Yes □ No If yes, what were the problems?

____

SOCIAL HISTORY

Male /Female **Married / Single** **Occupation** ________________________________

Do you regularly use tobacco products? □ Yes – How much? ___________ □ No □ Quit – when? ___________________
Do you use recreational drugs? □ Yes □No If yes – What?__________________ Date last used?___________________
Do you drink alcoholic beverages? □Yes □No If yes – What?___________How much?________Date of last drink_____

FAMILY HISTORY:

Adopted? Yes / No If not adopted, complete the family information below.

	Gastrointestinal Problems	Cancer (**Type**)?	If Deceased, Cause?
Father			
Mother			
Sisters			
Brothers			

Any other blood relatives with a history of cancer (please list type)? ______________________________________

____

Patient Signature ____________________________**Date**_________REVIEWED: Date/Initials _________________

GASTROENTEROLOGY ASSOCIATES of ROCHESTER, LLP

Patient's Name: ____ Date of Birth: _____________

Please check ALL that apply currently and sign below.

REVIEW OF SYSTEMS

GASTROINTESTINAL
___Gas ___Abdominal cramps
___Constipation ___Diarrhea
___Heartburn ___Bloating/swelling
___Nausea ___Trouble swallowing
___Vomiting ___Hemorrhoids
___Blood in stool ___Rectal pressure
___Rectal itching ___Rectal pain/burning
___Leaking/soiling ___Liver disease/problems

GENERAL

___Weight loss (amount ____ since when?______)
___Chills ___Chronic Fatigue
___Fever ___Night Sweats

EARS, EYES, NOSE & THROAT
___Cataracts ___Glaucoma
___Eye infections ___Poor vision/Vision loss
___Ear infections ___Ringing in ears (tinnitus)
___Nasal/sinus symptoms

HEART (Cardiovascular)

___Chest pain ___High blood pressure
___Palpitations ___Irregular heart beat
___Phlebitis ___Blood clots
___Ankle swelling ___Pacemaker/defibrillator

LUNGS (Respiratory)
___Asthma ___Bronchitis
___Cough ___Pneumonia
___Shortness of breath ___Home oxygen use
___Sleep apnea

URINARY
___Decrease urine force/flow
___Kidney stones ___Painful urination
___Blood in urine ___Urination at night
___Urinary tract infections

BONES & JOINTS (Musculoskeletal)

___Gout ___Muscle aches
___Osteoporosis ___Back pain
___Joint pain ___Joint swelling

SKIN
___Hives ___Rashes
___Allergic reactions

NEUROLOGIC/PSYCHIATRIC

___Headache (constant)
___Dizziness ___Migraines
___Memory loss ___Seizures
___Stroke ___Tremors
___Numbness/tingling
___Anxiety ___Depression
___Panic attacks ___Nervousness

ENDOCRINE
___Diabetes (when diagnosed________)
___Thyroid disease

HEMATOLOGIC/LYMPH
___Anemia ___Easy bruising
___Excessive bleeding

Patient's Signature: ____ Date: _______________

Reviewed: Date/Initials_______________________________