**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**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 □ Sleep Apnea/CPAP □ Other\_\_\_\_\_\_\_\_\_\_\_

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

\*\*\*\*\*\*\*Do you have a history of falls? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*\*\*\*\*\*\*\*\*

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**

**ENDOSCOPIC PROCEDURES**

**Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a ride home?** □ **Yes**  □ **No Do you have someone spending 12 hours with you?**  □**Yes** □ **No**

**Responsible Party/Driver:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number where you can be reached after your procedure: Day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Evening\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you are a diabetic, check your blood glucose prior to your procedure. BG result \_\_\_\_\_\_ Time: \_\_\_\_\_ **Weight \_\_\_\_\_\_\_\_\_\_\_\_\_**

\*\*If you have a pacemaker/defibrillator, please bring the identification card with you. Please let your Doctor know if you have a pacemaker or defibrillator prior to your appointment day.

**MEDICATION/ALLERGY LIST/RECONCILIATION FORM**

* **Medications must be listed on this form, not on a separate piece of paper to be attached.**
* In order to serve you most efficiently, please list all of your **current medications,** including any **over the counter medications, vitamins, or herbal supplements** that you are taking. This includes any medications, such as **aspirin or anticoagulants**, that you have stopped for this procedure.

 **MEDICATION/DOSAGE MEDICATION/DOSAGE**

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**Do you take any medications for erectile dysfunction or pulmonary hypertension (Viagra, Cialis)? \_\_\_\_\_Last dose: \_\_\_\_\_\_\_**

**ALLERGY FLAG**

□ NO KNOWN ALLERGIES

Are you allergic or sensitive to any medications? (Example, has any medication ever caused respiratory issues or skin rashes) □ Yes □ No If yes, name of medication and reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you allergic to Latex (Rubber) □ Yes □ No If yes, type of reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any foods? □ Yes □ No If yes, please list food and reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pre-Procedure Reconciling Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pre-Procedure Reconciling MD Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reconciliation Date:\_\_\_\_\_\_\_\_\_\_\_ Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**