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

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:_____

_____

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:_____

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 _____