Hudson County Gastroenterology GROUP P.A.

235 60th St
West New York, NJ 07093
T: (201) 854-4646

Please fill out the following form completely so that we may obtain the necessary information for our files and background information on your medical problem. In this way, more time will be available for you to talk to the doctor at the time of your visit. All information is held in strict confidence and will NOT be released to anyone without your written consent.

PATIENT INFORMATION - *Please print all information*

Date: _____

Patient ID Number: _____ (for office use)

Primary Care Physician: _____

Referring Physician: _____

Phone Number: (___) _____

Name: _____ Date of Birth: _____ Age: _____
Last First Middle mm/dd/yy

Address: _____ Sex: _____ Race: _____
Street City State Zip

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____ SSN: _____

Occupation: _____ Employer: _____

Person to notify in case of emergency: _____ Relationship: _____ Phone Number: (___) _____

Insured information: _____ Insured DOB: _____ Insured SSN: _____
(If different from above)

Insurance Company:(1) _____ (2) _____

Plan 1 ID Number: _____ Plan 2 ID Number: _____

Plan 1 Group Number: _____ Plan 2 Group Number: _____

SOCIAL HISTORY

Do you live: _____ Alone _____ With Spouse _____ with Family _____ Other: _____

Religion: _____ Marital Status: Married Single Widowed Divorced _____

Please indicate **TOBACCO USE:** _____ None

_____ Cigarettes: _____ packs per day _____ years of use Quit: _____(please list year)

_____ Other (Cigar/Snuff): _____ frequency/day _____ years of use Quit: _____(please list year)

Please indicate **ALCOHOL USE:** _____ None

How many glasses/cans do you drink: _____ daily _____ weekly _____ occasionally

WHAT MEDICAL PROBLEM BROUGHT YOU TO SEE THE DOCTOR TODAY?

_____

_____

WHAT DATE DID THE SYMPTOMS START? _____

WHAT MAKES THE SYMPTOMS BETTER? _____

WHAT MAKES THE SYMPTOMS WORSE? _____

PREVIOUS TREATMENT:

EMERGENCY ROOM: _____ YES _____ NO WHERE? _____

DOCTOR'S OFFICE: _____ YES _____ NO WHERE? _____

ALLERGIES: Please check any allergies that apply to you _____ No known drug allergies

Are you allergic to: ____ Latex ____ Penicillin ____ Sulfa ____ Lodine ____ Tetanus Other: _____

What are the complications from your allergy:

____Nausea ____Hives ____Rash ____Swollen Throat ____Difficulty Breathing Other: _____

CHECK ALL DISEASES THAT HAVE OCCURRED IN YOUR FAMILY and INDICATE FAMILY MEMBER AFFECTED (mother, father, sister, brother, grandparents, etc.)

Anemia	Breast Cancer	Cirrhosis of Liver	Colon Polyps	Colorectal Cancer
Crohn's Disease	Diabetes, NIDDM	Diabetes, Insulin Dependant	Gastric Cancer	Gallstones
Heart Disease	Hemochromatosis	Irritable Bowel Syndrome	Liver Disease	Gynecological Ca
Pancreatic Cancer	Acute Pancreatitis	Chronic Pancreatitis	Peptic Ulcer Disease	Ulcerative Colitis
Other:				

PAST MEDICAL HISTORY: Do you now or have YOU ever had any of the following illnesses, check all that apply.

CANCER
- ❑ Colon Cancer
- ❑ Esophageal Cancer
- ❑ Stomach Cancer
- ❑ Breast Cancer
- ❑ Pancreatic Cancer
- ❑ Endometrial Cancer
- ❑ Barrett's Esophagus
- ❑ Liver Cancer
- ❑ Leukemia
- ❑ Lymphoma

RENAL
- ❑ Kidney Stones
- ❑ Kidney Failure
- ❑ Dialysis

MUSCULOSKELETAL
- ❑ Fibromyalgia
- ❑ OsteoArthritis
- ❑ Rheumatoid Arthritis
- ❑ Raynaud's
- ❑ Lupus
- ❑ Sjogrens
- ❑ Scleroderma
- ❑ Gout

PSYCHOLOGICAL
- ❑ Bipolar
- ❑ Anxiety
- ❑ Depression
- ❑ Obsessive Compulsive Disorder
- ❑ Schizophrenia

LIVER
- ❑ Hemochromatosis
- ❑ Cirrhosis
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Jaundice
- ❑ Fatty Liver

HEART
- ❑ High Blood Pressure (Hypertension)
- ❑ Heart Attack (Myocardial Infarction)
- ❑ Angina
- ❑ Congestive Heart Failure
- ❑ Premature Heart Disease in Family
- ❑ Palpitations
- ❑ Mitral Valve Prolapse
- ❑ Elevated Triglycerides
- ❑ Elevated Cholesterol (Hyperlipidemia)
- ❑ Rheumatic Fever
- ❑ Heart Valve Disease
- ❑ Endocarditis

BLOOD
- ❑ VonWillebrands'
- ❑ Hemophilia
- ❑ Bleeding or clotting abnormalities

INTEGUMENTARY
- ❑ Eczema
- ❑ Skin Cancer
- ❑ Melanoma
- ❑ Psoriasis

NEUROLOGICAL
- ❑ Stroke
- ❑ eizures
- ❑ Migraines
- ❑ Other Headache

RESPIRATORY
- ❑ COPD (Emphysema)
- ❑ Asthma
- ❑ Tuberculosis (TB)
- ❑ Sleep Apnea
- ❑ Collapsed Lung

GASTROINTESTINAL
- ❑ IBS-Irritable Bowel Syndrome
- ❑ Diverticulitis
- ❑ Diverticulosis
- ❑ Peptic Ulcer Disease
- ❑ Angiodysplasia of GI tract
- ❑ Gallstones
- ❑ Hoarseness
- ❑ Reflux Esophagitis
- ❑ IBD-Crohn's
- ❑ IBD-Ulcerative Colitis
- ❑ Pancreatitis

ENDOCRINOLOGY
- ❑ Diabetes, Type I (insulin needed)
- ❑ Diabetes, Type II (pills needed)
- ❑ Thyroid Disease
- ❑ Hypothyroid
- ❑ Hyperthyroid

SURGICAL PROCEDURES/HOSPITALIZATIONS: Indicate the date of any surgeries you have had

GASTROINTESTINAL
- ❑ Appendectomy
- ❑ Hiatal Hernia Repair
- ❑ Cholecystectomy (Gallbladder Removal)
- ❑ Exploratory Surgery for Intestinal Adhesions
- ❑ Gastric Bypass
- ❑ Colon Resection, partial
- ❑ Gastric Resection, complete
- ❑ Splenectomy (removal of spleen)
- ❑ Ventral Hernia
- ❑ Incisional Hernia
- ❑ Colonoscopy
- ❑ Upper Endoscopy
- ❑ ERCP
- ❑ Whipple

GYNECOLOGICAL
- ❑ Vaginal Hysterectomy
- ❑ Abdominal Hysterectomy
- ❑ Ovary Removal (Oopherectomy)
- ❑ C-Section
- ❑ Breast Biopsy
- ❑ Mastectomy (Right, Left or Both)

GU
- ❑ TURP
- ❑ Bladder Surgery
- ❑ Inguinal Hernia
- ❑ Cystectomy with Ileal conduit
- ❑ KidneyRemoval (nephrectomy)
- ❑ Prostate Removal (prostatectomy)
- ❑ Radiation for prostate cancer

CARDIAC
- ❑ Heart Stent placed
- ❑ CABG
- ❑ Abdominal Aneurysm repair
- ❑ FemPop Bypass (Leg Arteries)
- ❑ Heart Valve replacement

OTHER
- ❑ Thyroidectomy
- ❑ Tonsillectomy
- ❑ Glaucoma Surgery
- ❑ Cataract Surgery
- ❑ Laser Surgery

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS

*Please check any symptom or disease diagnosed during the **last 2 months** (Items left blank indicate a negative response)*

GENERAL
- ❑ Loss of Appetite/Anorexia
- ❑ Fatigue
- ❑ Fever
- ❑ Night Sweats
- ❑ Weight gain in the last 2 months Amount_____
- ❑ Weight loss in the last 2 months Amount_____
- ❑ Are you under any stress?

SKIN
- ❑ Puritis/Itching
- ❑ Skin Rash

ENT
- ❑ Headache
- ❑ Eye Pain
- ❑ Eye Redness
- ❑ Visual Loss
- ❑ Nasal inflammation
- ❑ Nose bleed(s)
- ❑ Bleeding gums
- ❑ Hoarseness
- ❑ Oral Ulcers
- ❑ Voice Changes

HEMATOLOGY
- ❑ Enlarged Lymph Nodes
- ❑ Prolonged Bleeding

GENITOURINARY
- ❑ Blood in urine
- ❑ Painful urination
- ❑ Frequent urination
- ❑ Urgency with urination

RESPIRATORY
- ❑ Chest Pain
- ❑ Claudications
- ❑ Edema/Swelling
- ❑ Night Cramps
- ❑ Difficulty breathing while laying down
- ❑ Palpitations
- ❑ Sleep Apnea
- ❑ Shortness of Breath
- ❑ Congestive Heart Failure
- ❑ Myocardial Infarction
- ❑ Valve Replacement

ENDOCRINE
- ❑ Extreme thirst
- ❑ Frequent Urination

NEUROLOGICAL
- ❑ Difficulty Speaking
- ❑ Focal Neurological Symptoms
- ❑ Syncope
- ❑ Incontinence Urine
- ❑ Incontinence Stool
- ❑ Seizures

PSYCHIATRIC
- ❑ Feel scared or anxious
- ❑ Depression
- ❑ Feel like crying for no reason
- ❑ Insomnia/Trouble Sleeping

GASTROINTESTINAL
- ❑ Frequent constipation
- ❑ Pain with bowel movement
- ❑ Pale, greasy, oily or rancid stools
- ❑ Mucus in or on your stool
- ❑ Frequent diarrhea
- ❑ Black or sticky stools
- ❑ Blood in or on your stools
- ❑ Vomit frequently
- ❑ Vomit blood or “coffee grounds”
- ❑ Bloating, belching or excessive gas
- ❑ Difficult or painful swallowing
- ❑ Frequent heartburn or indigestion
- ❑ Frequent stomach pain
- ❑ Recent changes in your bowel movement

MEDICATIONS

Please check any PRESCRIBED and OVER THE COUNTER medications, including vitamins, supplements, medicated drops and injections

MEDICATION	DOSE	START DATE	PRESCRIBED BY