mlga Main Line Gastroenterology Associates

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:_____ D.O.B_____

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 heartbeat / 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, etc.)? 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.**

Would you like a chaperone during any part of your exam? YES NO

Name: _____ Date of Birth: _____

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

____Abdominal aortic aneurysm (I71.4)
____Anemia (D64.9)
____Arthritis (M19.90)
____Arthritis, Rheumatoid
____Asthma (J45.9_ _)
____Atrial Fibrillation (I48.91)
____Bladder Infection (N30.90)
____Cancer: _____
____Chemotherapy, currently
____Breast Cancer, history (Z85.3)
____Colon polyps, personal history (Z86.010)
____Colon cancer, personal history (Z85.038)
____Celiac Disease (K90.0)
____Cirrhosis (K74.60)
____Coronary Artery Disease (I25.10)
____Crohn's Disease (K50.90)
____Diabetes (E11.9)
____Diverticulosis (K57.90)
____Elevated Cholesterol (E78.0)
____Emphysema (J43.9)
____Endocarditis (Infected Heart Valve) (I38)
____Endometriosis (N80.9)
____Fibromyalgia (M79.7)
____Gallstones (K80.20)
____Gastritis (K29.70)
____GERD – Gastroesophageal Reflux (K21)
____Glaucoma (H40.9)
____Heart Attack (I21.3)
____Hemorrhoids (K64.9)
____Hepatitis (K75.9)
____Hepatitis B (B19.10)
____Hepatitis C (B19.20)
____Hepatitis due to alcohol (K70.10)
____Hiatal Hernia (K44.9)
____High Blood Pressure (I10)
____HIV
____Intestinal Bleeding (K92.2)
____Irritable Bowel Syndrome (K58.9)
____Kidney Disease (N18.3)
____Kidney Infection (N15.9)
____Kidney Stone (N20.0)
____Lyme Disease (A69.20)
____Osteoporosis
____Pancreatitis (K85.9)
____Peptic Ulcer (K27.3)
____Radiation Therapy, current or past
____Sleep Apnea (G47.30)
____Stroke
____Thyroid, overactive (E05.90)
____Thyroid, underactive (E03.9)
____Ulcerative Colitis

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.*

____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?

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

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 #_____

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_____

Primary Care Doctor_____Phone_____

List other doctors seen regularly_____Phone_____

_____

Who recommended that you consult a gastroenterologist? _____

INSURANCE INFORMATION

Insurance company and address_____

Name of Policyholder_____Group#_____

Policy/ID#_____ Medicare#_____

Policyholder employer_____ Policyholder Date of Birth_____

Your appointment time has been set aside for you. We reserve the right to bill for missed and cancelled appointments. Please provide us with 24 hours' notice if you need to cancel your office visit and two business days if you need to cancel a procedure. Otherwise, missed or late cancellations may result in a discharge from the practice. Late cancellations delay the care for other patients who are waiting to be seen in a timely fashion. Please confirm though our automated system when you receive your reminder.

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

ACKNOWLEDGMENT 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**