capitalhealth

Patient Name: _____

DOB: _____

SPECIALIST INFORMATION

Please list your primary care physician as well as any specialist information below in the subsequent sections such as gastroenterologist, cardiologist (heart doctor), rheumatologist (arthritis doctor), endocrinologist (diabetes doctor), neurologist (stroke or MS doctor), etc. This way we can keep all of your physicians informed about your health. This form will be updated EVERY year & we will as for your signature verifying our records are correct. Thank you, in advance, for your anticipated cooperation.

Patient Name: _____ DOB: _____ Date: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Previous Gastroenterologist: Name _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #1: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #2: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Patient Signature: _____ Date: _____

Patient's Initials: _____ Date: _____ Patient's Initials: _____ Date: _____

Patient's Initials: _____ Date: _____ Patient's Initials: _____ Date: _____

Patient Name: _____

DOB: _____

Specialist #3: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #4: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #5: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #6: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #7 _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #8: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Capital Health Gastroenterology Specialists

New Patient Encounter Form

Patient Name: _____

DOB: _____

Please complete this form to the best of your ability.

1. Reason(s) for your visit today: _____

_____

2. Medical History – Please check all that apply:

☐ Colon Cancer or Polyp	☐ Heart Attack or Chest Pain	☐ Diabetes
☐ Pancreatitis	☐ Pacemaker or Defibrillator	☐ Stroke
☐ Esophageal or Gastric Cancer	☐ Atrial Fibrillation	☐ Asthma or Chronic Lung Disease
☐ Pancreas Cancer	☐ High Blood Pressure	☐ Chronic Kidney Disease
☐ Barrett's Esophagus	☐ Elevated Cholesterol	☐ Bleeding Disorder
☐ GERD or Heartburn	☐ Blot Clot in Leg or Lung	☐ Sleep Apnea
☐ Crohn's or Ulcerative Colitis	☐ Heart Failure	☐ In Dialysis
☐ Gastroparesis	☐ Last Menstrual Period: _____	

☐ Other gastrointestinal diseases, please specify: _____

_____

☐ Other, please list: _____

_____

3. Please list **ALL** medication(s), including over-the-counter medications or supplements you are taking, including dosage & frequency:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Height: _____ Weight: _____

Patient Name: _____

DOB: _____

4. Previous surgeries/dates - Please check all that apply & list date(s) to your best recollection:

   ☐ Gallbladder _____ ☐ Colon/Intestine _____ ☐ Pancreas _____

   ☐ Esophagus or _____ ☐ Heart Bypass _____ ☐ Heart Valve _____

   Stomach

   ☐ Hysterectomy _____ ☐ Appendix _____ ☐ Hernia _____

   ☐ Other – Please list: _____

5. Allergies – Are you allergic to any medication(s)? ☐ No ☐ Yes If yes, please list the medications you are allergic to & your reaction: _____

   _____

   Do you have any food allergies? ☐ No ☐ Yes If yes, please list: _____

   _____

6. Social history?

   Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widow/Widower

   With whom do you live? _____

   Current occupation/employer: _____

   Do you smoke? ☐ Yes ☐ No If yes, how many packs a day? _____ For how many years? _____

   Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks a day? _____ a week? _____ a month? _____

   Are you sexually active? ☐ Yes ☐ No Do you use Marijuana ? ☐ Yes ☐ No

   Do you use illicit drugs? ☐ Yes ☐ No If yes, what kind?

   _____

7. What is the health status of your family?

   Mother: _____ Father: _____

   Brothers/Sisters: _____

   Family Illnesses:

   History of Colon Cancer? ☐ Yes ☐ No

   History of Pancreatic Cancer? ☐ Yes ☐ No

   History of Uterine Cancer? ☐ Yes ☐ No

   Other Cancer? ☐ Yes ☐ No If yes, site _____

Patient Name: _____

DOB: _____

8. Review of Systems – Do you have signs or symptoms in any of the following areas? Please check all that apply.

Yes	No		Yes	No	
		Constitutional			**Cardiovascular**
☐	☐	Fever, sweats or chills	☐	☐	Chest pain
☐	☐	Fatigue, anorexia	☐	☐	Palpitations
☐	☐	Weight loss >5lbs	☐	☐	Ankle swelling
☐	☐	Weight gain	☐	☐	Difficulty breathing upon lying down
		Skin			**Respiratory**
☐	☐	Rashes	☐	☐	Shortness of breath
☐	☐	Jaundice	☐	☐	Cough
☐	☐	Skin cancer	☐	☐	Sputum production
		Eyes	☐	☐	Snoring
☐	☐	Dry eyes or eye irritation	☐	☐	Dry mouth, mouth ulcers
☐	☐	Change in vision	☐	☐	Sore throat
		Ears, Nose, Mouth & Throat			**Psychiatric**
☐	☐	Nose, sinus problems	☐	☐	History of anxiety or depression
☐	☐	Earache	☐	☐	Sleep disturbances
☐	☐	Allergies			**Neurological**
		Gastrointestinal	☐	☐	Headache
☐	☐	Heartburn or indigestion	☐	☐	Focal weakness or numbness
☐	☐	Difficulty swallowing	☐	☐	Loss of consciousness
☐	☐	Nausea or vomiting	☐	☐	Dizziness, fainting
☐	☐	Abdominal pain			**Musculoskeletal**
☐	☐	Jaundice or hepatitis	☐	☐	Muscle aches
☐	☐	Diarrhea	☐	☐	Arthritis or arthralgia
☐	☐	Constipation	☐	☐	Chronic back pain
☐	☐	Red or black blood colored stools			**Genitourinary**
☐	☐	Fatty food intolerance	☐	☐	Frequent, difficult or painful urination
☐	☐	Fecal incontinence	☐	☐	Nighttime urination
☐	☐	Early fullness	☐	☐	Irregular menstrual periods or vaginal bleeding
			☐	☐	Urethra or vaginal discharge

Physician Comments – Review of Systems:

Other Symptoms:

I have personally reviewed the information recorded in the above three pages

Attending Signature _____ Date _____