HUDSON VALLEY GASTROENTEROLOGY, P.C.

PATIENT NAME: ______________________________ D.O.B.______________________DATE:_______

PATIENT INTAKE FORM

Please provide the following answers on the line **UNDER** the question. Thank you.

Please list all current medications with dosages including over the counter medications.

__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________

Do you have any known allergies or sensitivities including those to metals? Please list reaction.

____

Have you had any surgeries or procedures that required anesthesia in the past? What, when, and were there any complications to anesthesia?

____

Please list any medical problems on the line below.

____

Please list any assistive devices you may use. (ex: glasses, cane, walker)

____

Have you had a Pneumonia vaccination? If yes, when? __________________________________

Did you have an Influenza vaccine (flu shot?) If yes, when? _____________________________

Do you have a Health Care Proxy? If yes, please provide name and relationship.

____

Do you have any advance directives? (i.e. Do Not Resuscitate or any other instructions.)

____

Women: Date of last Mammo:______________ Date of last Pap Smear:______________

If you were born between 1945-1965 have you ever been tested for Hepatitis C?
Yes:__ No:__ Unsure:__ If results positive, were you previously treated? ____

FAMILY HISTORY: *(circle all that apply)*

FATHER:

High blood pressure	Anemia/Sickle Cell	Other: ________________
Heart Disease	Gallstones	
Stroke	Colon Polyps	Deceased? Cause?_______
Diabetes	Colon Cancer	
Liver Disease	Other Cancer: _______________	

MOTHER:

High blood pressure	Anemia/Sickle Cell	Other: ________________
Heart Disease	Gallstones	
Stroke	Colon Polyps	Deceased? Cause?_______
Diabetes	Colon Cancer	
Liver Disease	Other Cancer: _______________	

SIBLINGS: **How many?** ______

High blood pressure	Anemia/Sickle Cell	Other: ________________
Heart Disease	Gallstones	
Stroke	Colon Polyps	Deceased? Cause?_______
Diabetes	Colon Cancer	
Liver Disease	Other Cancer: _______________	

CHILDREN: **How many?** ______

High blood pressure	Anemia/Sickle Cell	Other: ________________
Heart Disease	Gallstones	
Stroke	Colon Polyps	Deceased? Cause? _______
Diabetes	Colon Cancer	
Liver Disease	Other Cancer: _______________	

SOCIAL HISTORY:

Marital Status: Single ___ Widowed ___ Divorced ___ Married___ Domestic Partnership___
Legally Separated___ Never Married___

Lives with: Alone___ Children___ Spouse___ Mother&Father___ Other: __________

Religious Preference ____________________

Work Status: Full Time___ Part Time___ Retired___ Unemployed___ Disabled___

*Occupation:*___________________________

Smoking: Yes___ No___ Former Smoker___ If yes, how much per week? __________________

Alcohol: Yes___ No___ If yes, how much per week?________________________

Are you or have you used recreational drugs? Yes___ No___ When/Type_________________________

Any piercings? Yes___ No___ If yes, where?__________________________

Any tattoos? Yes___ No___ If yes, was it done with lead ink? Yes___ No___

Have you traveled out of the country recently? Yes___ No___ If so, where and when? __________________

Hudson Valley Gastroenterology

Name:	Date:	DOB:

Yes	No	CONSTITUTION
		Decreased Appetite
		Fatigue
		Fever
		Weight Loss
		Weight Gain

Yes	No	EYES
		Cataracts
		Glaucoma
		Corrective Lenses

Yes	No	ENMT
		Hearing loss
		Seasonal Allergies
		Congestion
		Nose Bleeding
		Mouth Breathing
		Septal Deviation, Nasal
		Bleeding Gums
		Chronic Cough
		Dental Problems
		Hoarseness/Voice Change
		Hemoptysis - Coughing Up Blood
		Mouth Sores
		Thrush
		TMJ Jaw Discomfort

Yes	No	HEART
		Angina, Chest Pain
		Arrhythmia
		Automatic Defibrillator
		CHF Congested Heart Failure
		Congenital Heart Disease
		DVT Vein Thrombus/Clots
		High Cholesterol
		High Blood Pressure
		MI - Heart Attack
		Pacemaker
		Blood Vessel Disease

How did you hear about us?

*MD Referral*______________

*Newspaper*______________

*Phonebook*______________

*Internet*________________

*Family/Friend*____________

*Other*__________________

Yes	No	RESPIRATORY
		Asthma
		Difficulty Breathing
		COPD - Emphysema
		History of Lung Blood Clots
		Snoring
		Pneumonia
		Sleep Apnea

Yes	No	MUSCULAR
		Arthritis
		Fibromyalgia
		Osteoporosis

Yes	No	SKIN
		Bruising
		Skin Cancer
		Piercings
		Psoriasis
		Reynaud's
		Tattoos with Lead Ink

Yes	No	BREAST
		Cancer

Yes	No	NEURO
		CVA, Stroke
		Headache
		Memory Loss
		Parkinson's Disease
		Restless Leg Syndrome
		Seizures
		TIAs Mini Strokes

Yes	No	PSYCH
		Anxiety
		Eating Disorder
		Depression

Yes	No	ENDOCRINE
		Diabetes 1 or 2 (circle)
		Kidney Disease
		Thyroid Disease

Yes	No	HEMA/Lymph
		Bleeding/ Clotting Disorder
		Blood Transfusion
		Sickle Cell Anemia