NORTH SHORE GASTROENTEROLOGY ASSOCIATES, P.C.
233 EAST SHORE ROAD, SUITE 101
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SHAHEEN KHALFAN, RPA-C
REBECCA BIKRAM, RPA-C

Please have your primary care physician mail or fax your recent blood tests (done within one year) to our office.

If you have not had your labs drawn within the past year, please call your primary care physician to have them drawn. We require CBC and CMP.

Thank you.

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NAME:______________________________AGE:______BIRTHDATE:_____/_____/_____

ADDRESS:______________________CITY:______________STATE:_____ZIP:______

PHONE: Home (   )__________________Work: (   )____________________

CELL: (   )__________________E-MAIL ADDRESS:______________________

SS#:____________________SEX:______MARITAL STATUS:__________________

EMPLOYER NAME:__________________OCCUPATION:______________________

PRIMARY MD NAME: __________________PHONE: (   )____________________

ADDRESS:________________________CITY:___________STATE:_____ZIP:_______

EMERG. CONTACT NAME:__________________EMERG. PHONE: (   )__________

RELATIONSHIP TO PT.:____

REASON FOR TODAY'S VISIT:____

____

PHARMACY NAME, ADDRESS & PHONE NUMBER:______________________________

____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:____

I.D. #:______________________________GROUP #:______________________

POLICY HOLDER'S NAME:__________________RELATIONSHIP TO PT.:__________

SOCIAL SECURITY #:____________________DATE OF BIRTH:_______________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:____

I.D. #:______________________________GROUP #:______________________

POLICY HOLDER'S NAME:__________________RELATIONSHIP TO PT.:__________

SOCIAL SECURITY #:____________________DATE OF BIRTH:_______________

I hereby authorize the Doctors of North Shore Gastroenterology Associates, P.C. to furnish any and all records pertaining to medical history, services rendered, or treatment given to me or my department for purposes of review, investigation, or evaluation of claims. I authorize payment of medical benefits to North Shore Gastroenterology Associates, P.C., and acknowledge that I am financially responsible for any unpaid balance. I have been provided access to North Shore Gastroenterology Associates, P.C. HIPPA policies.

PATIENT OR AUTHORIZED SIGNATURE:___________________________DATE:__________

rev 8/11

North Shore Gastroenterology Associates: Patient History Form

Name____Date____/____/20____

REASON FOR TODAY'S VISIT: (short sentence)________________________________

____

PAST MEDICAL HISTORY: (circle yes or no)

Yes No – Hypertension
Yes No – Diabetes
Yes No – Pneumonia
Yes No – Asthma
Yes No – Emphysema

Yes No – Lyme Disease
Yes No – Venereal Disease
Yes No – Mononucleosis
Yes No – Arthritis
Yes No – Stroke

Yes No - Rheumatic Fever
Yes No - Thyroid Disease
Yes No – Gout
Yes No – Depression

Yes No – Cancer site/date diagnosed________________________________
Yes No – Heart Attack Date________________________________
Yes No – Angina. If yes, last episode________________________________

Yes No - Other. Specify________________________________

PAST SURGICAL HISTORY: (circle yes or no)

Yes No – Tonsils
Yes No – Appendix
Yes No – Hernia, location__________
Yes No – Gallbladder, open or laparoscopic

Yes No – Cesarean Section
Yes No – Hysterectomy
Yes No – Abdominal Aortic Aneurysm Repair
Yes No – Other________________________________

MEDICATIONS: (please list)

Name	Dose (mg,g)	Frequency

Yes No – **Allergies** to medications and reaction:________________________________

Yes No – Do you take **Aspirin**/anti-inflammatory meds? (NSAIDS e.g. Advil, Motrin) specify:

SOCIAL HISTORY (circle yes or no):

Yes No – Do you smoke cigarettes? If yes, how much daily?________________________________

If you previously smoked, when did you quit?________________________________

Yes No – Do you drink alcohol? If yes, how much in a week?________________________________
Yes No – Do you drink coffee or tea? If yes, how much daily?________________________________
Yes No – Have you traveled recently to tropical countries? If yes, where?________________________________
Yes No – Have you ever received a blood transfusion (# of units/when?)________________________________
Yes No – Have you had (within 1 year) routine blood work drawn?
(Location/telephone#)________________________________

(rev 9/07)

Name____Date____/____/20____

FAMILY HISTORY – (Note: not your own history) (circle yes or no):

Yes No – colon cancer (specify name of relative/age at diagnosis)________________________________
Yes No – colon polyps (specify name of relative/age at diagnosis)________________________________
Yes No – ulcerative colitis or Crohn's disease____
Yes No – breast cancer or ovarian cancer____
Yes No – other significant____

REVIEW OF SYSTEMS (circle yes or no):

Skin:
Yes No – rash
Yes No – itching
Yes No – jaundice

Neurologic:
Yes No – headache
Yes No - focal weakness
Yes No – numbness
Yes No – fainting

Eyes:
Yes No - visual loss
Yes No - double vision
Yes No – pain

Ears/Nose/Throat:
Yes No - hearing loss
Yes No - ringing in the ears
Yes No – dizziness
Yes No - runny nose
Yes No – nosebleed
Yes No - sore throat
Yes No – hoarseness

Respiratory:
Yes No - shortness of breath
Yes No – cough
Yes No – wheezing
Yes No - coughing up blood
Yes No - pain with breathing

Cardiovascular:
Yes No – palpitations
Yes No - chest pain/tightness with exertion
Yes No - shortness of breath with exertion
Yes No - awakening at night short of breath
Yes No - swelling of ankles or lower legs
Yes No - aching muscles or joints

Gastrointestinal:
Yes No - frequent or severe heartburn
Yes No - excessive belching
Yes No - food getting stuck when swallowing
Yes No - abdominal pain
Yes No – nausea
Yes No – vomiting
Yes No - vomiting blood
Yes No – constipation
Yes No - change in caliber of stool
Yes No - diarrhea
Yes No - black colored stool (like tar)
Yes No - excessive flatulence
Yes No - Ever had a barium enema? When?_________________
Yes No - Ever had endoscopy? When?______________________
Yes No - Ever had colonoscopy? When?____________________
Yes No - Ever had sigmoidoscopy? When?__________________
Yes No - Ever had a GI series? When?_____________________

Urinary:
Yes No - frequent urination
Yes No - pain or burning with urination
Yes No - constant feeling of an urge to urinate
Yes No - dark or bloody urine

Men:
Yes No - weak or slow urinary stream
Yes No - prostate problems
Yes No - swelling or lumps in the testicles
Yes No - burning or discharge from the penis

Women:
Yes No - no longer get periods
Yes No - irregular menstrual periods
Yes No - heavy menstrual periods

Rheumatologic:
Yes No – swollen joints
Yes No – back pain