Gastroenterology Group of Rochester, LLP

Name: ______________________ DOB: __________ Age: ________ Today's date: ______________

Referring MD: ______________ PCP: ____________ OB/GYN: ______________ Height _____ Weight _____

Reason for visit : (Circle all that apply, or note reason in 'other') Screening colonoscopy History of polyps Rectal bleeding Diarrhea Weight loss Nausea Vomiting Abdominal pain Constipation Heartburn/reflux Barrett's esophagus Difficulty swallowing Crohn's disease Ulcerative colitis Other: ______________________________

Medications : (Include prescriptions, over-the-counter medications, vitamins/supplements, minerals, herbs) ** Note - If additional space is needed, attach separate sheet ☐ Separate sheet attached

Medication name	Dosage	How often taken

Use of anti-inflammatory products /Blood thinners : ☐ aspirin/Ecotrin ____________(mg) daily/wkly./as needed
☐ ibuprofen/Advil/Motrin ________(mg) daily/wkly./as needed ☐ naproxen/Aleve ________(mg) daily/wkly./as needed
☐ Coumadin/Plavix ________(mg) daily/wkly. ☐ Other: ______________________________

Allergies/Reactions: ☐ Sedatives/Anesthetics - Name / Type of reaction: ____________________
☐ Latex- Type of reaction: ______________________________ ☐ Adhesives/Tape/Bandaids
☐ Medications- Name/Type of reaction: ______________________________

Personal Medical History : (Circle all that apply; note 'past' or 'present')

	Past	**Present**
Neurological illness/Stroke /Seizure	____	______
Eye/ Ear/ Nose/ Throat/ Thyroid disease	____	______
Anxiety/Depression / Psychiatric disorder	____	______
Cancer * Type: ________________	____	______
(* **Please complete reverse side of form**)		
Chronic cough/Shortness of breath	____	______
Lung disease (Asthma/COPD)	____	______
Sleep apnea/ CPAP use	____	______
GERD/Barrett's esophagus	____	______
Heartburn/Reflux /Nausea/Vomiting	____	______
Difficult/Painful swallowing	____	______
High blood pressure/Heart valve disease	____	______
Angina/Heart attack/Cardiac stent	____	______
Irregular heartbeat/Pacemaker/Defibrillator	____	______
Anemia/Easy bruising or bleeding	____	______
Jaundice/Liver disease/Gallbladder disease	____	______
Bladder/Kidney stones or disease	____	______
Unexplained Wt. loss or gain/Eating disorders	____	______
Abdominal pain/Diarrhea/Constipation /IBS	____	______
Crohn's disease/Ulcerative colitis	____	______
Black/ Bloody stools	____	______
Polyps (Stomach or Colon)	____	______
Arthritis/Fibromyalgia/Gout	____	______
Diabetes/Hypoglycemia	____	______
Skin disease	____	______
Have you ever had a blood transfusion?	Yes - year(s) ________	No
Do you require antibiotics prior to dental work?	Yes	No

Other Chronic Medical Problems:

____
____
____
____

Form Reviewed by: ____________________ Date: ____________

Surgical History: (List type of surgery and surgery dates) ________________
____
____
____
____
____
____
____
____
____
____

Social History:

Alcohol/Drug use (How much/When quit):
____
______________________________ N/A

Tatoos/Piercings (Location(s), list year placed) :
____
____

Smoking (How much and when quit): N/A
____

Occupation: ____________________

Marital Status: ____________________

Dietary Habits:

(List how often you use any of the following, circle daily or weekly)

Milk amount ________ daily/weekly
Soda pop amount ________ daily/weekly
Coffee/Tea amount ________ daily/weekly
Gum chewing frequency ________ daily/weekly

Pt. Signature: ____________________

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Family History Questionnaire for Hereditary Colorectal Cancer Syndromes

Patient Name:________________________ Physician:________________________

Date of Birth:________________________ Date Completed:________________________

Instructions: Please circle N or Y to those that apply to YOU and/or YOUR FAMILY (on both your mother's and father's side). After each statement, please list the relationship to you of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) and age at diagnosis. Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary colorectal cancer syndromes; if you circle Y to any of the statements below, you MAY be appropriate for the genetic testing. Ask your healthcare provider for additional information.

			RELATIONSHIP	AGE AT DIAGNOSIS
HISTORY				
Y	N	10 or more colon polyps found in their lifetime	______	______
Y	N	Colorectal cancer before the age of 50	______	______
Y	N	Uterine cancer before the age of 50	______	______
Y	N	Both uterine & colorectal cancer	______	______
		(in an individual or a family)	______	______
Y	N	2 or more uterine or colorectal cancers (in an individual or a family)	______	______
Y	N	Uterine and/or colorectal cancer AND	______	______
		Ovarian, stomach, kidney/urinary tract, brain	______	______
		OR small bowel cancer (individual or a family)	______	______
OTHER FAMILY HISTORY				
Y	N	Esophageal cancer	______	______
Y	N	Stomach cancer	______	______
Y	N	Liver cancer	______	______
Y	N	Crohn's disease	______	______
Y	N	Ulcerative colitis	______	______

____

Patient's Signature Date

GASTROENTEROLOGY GROUP OF ROCHESTER, LLP

Please print all information in the spaces provided.

Last Name____________________________First Name_______________MI___Age_________

Home Address____

Home Phone______________Date of Birth___________ Male/Female SS#_______________
Please circle

Occupation__________________________________Employer_____________________________

Work phone__________________________________

Primary Insurance: **please bring insurance cards to ALL appointments**

Insurance Company name and phone number____

Billing address____

ID#____________________________Subscriber____

Secondary Insurance:

Insurance company name & phone number____

Billing address____

ID#____Subscriber_____________________________

Emergency contact:

Name_______________________________Phone #____________Relationship______________

I hereby authorize payment of medical benefits billed to my insurance to **Gastroenterology Group of Rochester, LLP.** I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I accept responsibility to obtain and supply any referrals and/or precertification numbers if needed to process any claims to my insurance. If such referral and/or precertification number are not provided at the time service is rendered, I will be responsible for the total amount due for services rendered.

I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

____ ________________________________
Signature of patient or guardian *Date*

Gastroenterology Group of Rochester, LLP

Anil K. Sharma, M.D. • Paul S. Dziwis, M.D. • George Y. Kunze, M.D. • Bushra G. Fazili, M.D. • Michael E. Kader, M.D. • Jonathan I. Goldstein, M.D. • KelleyAyn Wallace, RPA-C

Patient Consent

I consent to the use or disclosure of my protected health information by Gastroenterology Group of Rochester , ("the Practice"), for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills and to conduct health care operations of the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. I understand that the Notice of Privacy Practices is posted in the waiting room. The Practice reserves the right to change the Notice of Privacy Practices. I understand that I may request a copy of the Notice of Privacy Practices by asking the Receptionist for one during regular business hours.

____
Signature of Patient or Personal Representative

____
Print Name of Patient or Personal Representative

____
Date

919 Westfall Road • Bldg.C - Suite 100
Rochester, New York 14618

229 Summit Street, Suite 8
Batavia, New York 14020

495 Main Street
Canandaigua, New York 14424

1331 East Victor Road
Victor, New York 14564

(585) 271-2800 • fax (585) 271-0375
www.gastrogroupofrochester.com