Saratoga Schenectady Gastroenterology Associates, P.C.
Saratoga Schenectady Endoscopy Center, LLC
Phone: (518) 831-1500 Fax: (518) 377-1677

Medical History Form

Please provide us with a brief medical history: **Today's Date:______________**

Patient Name: ____ **Date of birth: ______________**

Patient Acct #: ________________________

Primary Insurance Company: ____

What is the reason for your visit?____

1. **From the list of symptoms below, please circle any that you have experienced recently.**

Nausea | Vomiting | Heartburn | Pain when swallowing

Black stools | Rectal pain | Constipation | Abdominal pain

Rectal bleeding | Loss of appetite | Diarrhea | Change in bowel habits

Weight loss | Difficulty swallowing (food gets stuck)

1. **From the list of medical conditions below, please circle any you have experienced in the past.**

Stomach ulcers | Duodenal ulcers | Hepatitis | Liver Disease

Colitis | Gallstones | Colon polyps | Diverticulosis or Diverticulitis

High Blood Pressure | Diabetes | Stroke | Heart disease or Heart attacks

Seizures | Arthritis | Problems Sleeping | Sleep apnea | COPD

Cancer If yes, what type of cancer?____

2. **Please list any other medical problems:** ____

____

4. **Do you have a pacemaker:** YES NO **Do you have an implanted Defibrillator** YES NO

5. **For women:**

Are you pregnant? Yes No Do you use contraceptives? Yes No

Last menstrual period (date): ____

6. **Please circle any surgeries you've had in the past.**

Appendectomy | Gallbladder removed | Cardiac Surgery | Stent Placement | Bowel

Surgery Hysterectomy | Colonoscopy/Sigmoidoscopy | If so when: _________________________

Please list all other surgeries you have had in the past:____

____

7. **Allergies to Medications:**____

____

Are you allergic to Eggs? YES NO If yes, what reaction:____

Are you allergic to Soy? YES NO If yes, what reaction:____

Are you allergic to Peanuts? YES NO If yes, what reaction:_____________________________________

Are you allergic to Nickel? YES NO If yes, what reaction:____

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ______________

Medical History Form Cont.

8. **Please list all medications including over the counter medications that you are currently taking, including dosage and frequency:**

   1. ______________________ 2. ______________________

   3. ______________________ 4. ______________________

   5. ______________________ 6. ______________________

9. **Are you prone to bleeding, or do you bleed easily?** Yes No

10. **Please circle any blood thinning Medications you take:**

    Aspirin Coumadin Plavix Xarelto Pradaxa Other

11. **Would you accept a blood transfusion if necessary after a procedure?** Yes No

12. **Social History** (Please indicate next to the items below how much you consume daily or weekly.)

    Tobacco ______________________ Soda ______________________

    Alcohol ______________________ Chocolate ______________________

    Coffee/tea ______________________

    Marital Status: Single Married Divorced Widowed Separated

    Occupation: ______________________

13. **Family History** (Please circle any conditions your family members have.)

    Colon Cancer: If yes, who? ______________________

    Ulcerative Colitis: If yes, who? ______________________

    Crohn's Disease: If yes, who? ______________________

    Liver Disease: If yes, who? ______________________

    Colon Polyps: If yes, who? ______________________

    Mother Alive? Yes No If not, cause of death: ______________________

    Father Alive? Yes No If not, cause of death: ______________________

14. **From the list of general symptoms below, please circle any you have experienced recently.**

Fevers	Rash	Headaches	Muscle aches
Double vision	Numbness/tingling	Cough	Anxiety/depression
Chest pain	Blurred vision	Trouble urinating	Loss of hearing
Blood in urine	Dizziness	Frequent urination	Shortness of breath
Intolerance to cold	Intolerance to heat	Leg swelling	painful or swollen glands
Excess sputum			

Physician's Signature: ______________________ **Date:** ______________________

Patient Registration Form

Account Number (Office use): ________________________

First Name: ________________ Last Name: ________________________ M.I.: Birth Date:

Address: City, State: Zip:

Home #: Work #: Cell #: Email:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Soc. Sec. #:

Sex: ☐ Male ☐ Female Employment Status: ☐ Employed ☐ Retired ☐ FT Student ☐ PT Student

Employer: Occupation:

Spouses Name: Spouses Birth Date:

We ask the following personal information as required under the "The American Recovery and Reinvestment act of 2009"

Primary Language: Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Race: ☐ American Indian/Alaska native ☐ Asian ☐ African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ other

☐ Although I understand you are required to ask for above information, I am choosing not to provide it.

Please indicate who your referring and primary doctor's are below!!! Thank You!!!

Referring Doctor's Full Name: Referring Doctor's Phone #:

Primary Care Doctor's Full Name: Primary Care Doctor's Phone #:

Person to Contact in an Emergency: Emergency Contact Phone #:

INSURANCE INFORMATION

If you are covered by more than one insurance company, the insurance which is in your name is your primary insurance. The insurance which is in your spouse's name is your secondary insurance. If you are covered by only one insurance company, then that is your primary insurance.

PRIMARY INSURANCE COMPANY

Ins. Co. Name:

Ins. Co. Address:

City: State: Zip:

Policy ID #:

Group #: Co-pay Amount: $

Policy Holder's Name:

Policy Holder's Date of Birth:

Policy Holder's Relationship to Patient:

Effective Date of Policy:

SECONDARY INSURANCE COMPANY

Ins. Co. Name:

Ins. Co. Address:

City: State: Zip:

Policy ID #:

Group #: Co-pay Amount: $

Policy Holder's Name:

Policy Holder's Date of Birth:

Policy Holder's Relationship to Patient:

Effective Date of Policy:

If person responsible for bill is not the patient, please fill in this section!!!

Person Responsible for bill: Their Phone #:

Their address:

City: State: Zip:

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Saratoga Schenectady Gastroenterology Associates, P.C. and Saratoga Schenectady Endoscopy Center, LLC and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information acquired in the course of my examination or treatment to my insurance company.

Signature: ____ **Date:** ____________________