**Gastroenterology HealthCare Associates, P.C.**

**Richard L. Curtis, M.D. Suite 368, Green Building**

**Dennis E. Lee, M.D. 2000 Washington Street**

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**Elissa E. Kaplan, M.D. Tel 617-969-1227**

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**Vera K. Denmark, M.D.**

Appointment Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Thank you for calling Gastroenterology HealthCare Associates and scheduling a new patient consultation.

Please complete the medical history on the back side. You will be given a medication list to look over at the time of your appointment or you may bring your medication list. ***Bring completed form*** with you to your appointment. **PLEASE DO NOT MAIL IT BACK.**

Please be sure to bring your current insurance card(s). If your insurance requires a referral from your Primary Care doctor please contact them prior to your appointment. If we do not have a referral on file at the time of your appointment you will be responsible for signing a referral waiver. If a ***co-pay*** is required by your insurance company it is ***due at the time of your visit***. This may be paid in cash, by check or credit card. ***Please make checks payable to GHCA***. ***\*\*\*Patients without their co payment will be rescheduled to another day.***

***Please arrive 15 minutes prior to your appointment in order to process your paper work and insurance information. If there is a change in your insurance you MUST call with your updated insurance information prior to your appointment.***

**IMPORTANT!**

**PLEASE REVIEW OUR CANCELLATION POLICY BELOW.**

**CANCELLATION/NO SHOW POLICY**

**FOR DOCTOR APPOINTMENTS**

We understand that there are times when you must miss an appointment due to an emergency or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

**If an office appointment is not cancelled within 24 hours of your appointment, you will be charged a twenty-five dollar ($25) fee. This fee is NOT covered by your insurance company.**

**Gastroenterology HealthCare Associates Medical History Form**

**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: **F/M** Height: \_\_\_\_\_\_Weight: \_\_\_\_\_\_\_ Primary care physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the reason for your visit?** Pleaselist all reasons and be **SPECIFIC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Review of Systems**

Have you had any of the symptomslisted below? **Circle all that apply.** If no mark **None.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SYSTEMS** |  |  |  | **NONE** |
| **Gastrointestinal** | Nausea/VomitingHeartburn/reflux,Black Stools, Bloating | Problems swallowing, Diarrhea, Constipation | Abdominal pain, Red blood in stools |  |
| **Constitutional** | Weight loss, Loss of appetite | Fatigue, Fever | Fever/chills |  |
| **Eyes** | Blurred vision, Glaucoma | Double vision | Vision loss |  |
| **Ear/Nose/Throat** | Hearing loss, Ringing in ears,Sinus pain | Mouth sores, Dry mouth,Sore Throat | Bleeding nose/gums, Neck pain |  |
| **Cardiovascular** | Chest Pain, Palpitations | Shortness of breath | Swelling of legs |  |
| **Respiratory** | Spitting up blood | Cough | Wheezing |  |
| **Hematology** | Easy bruising | Swelling of lymph nodes |  |  |
| **Neurological** | Headaches  | Numbness or tingling | Dizziness, Confusion |  |
| **Genitourinary** | Pain w/ urination, Blood in urine | Urine incontinence, Kidney stones | Urinary infections |  |
| **Musculoskeletal** | Joint pain or swelling | Muscle pain | Joint pain |  |
| **Psychiatric** | Thoughts of self-harm | Depression | Anxiety |  |
| **Skin** | Yellowing of the skin | Rash  | Itching |  |
| **Endocrine** | Heat/cold intolerance | Excessive thirst/urination |  |  |

**\*\*\*NEW PATIENTS PLEASE COMPLETE THE SECTION BELOW\*\*\*\***

**Past Medical History**

List prior and current medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List prior surgery/**operations:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Allergies:­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Medical History**

Mother: **Alive/Deceased** Medical Problems**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Father: **Alive/Deceased** Medical Problems**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Sibling(s): **Alive/Deceased** Medical Problems (**specify brother or sister**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Additional family medical history (**specify relationship**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social History**

Current Smoker: **Y/N** packs per day **\_\_\_\_\_\_\_**years\_\_\_\_\_\_\_ Former Smoker: **Y/N** packs per day**\_\_\_\_\_\_** years\_\_\_\_\_\_\_

Alcohol Use: **Y/N** how many \_\_\_\_\_how often\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Use: **Y/N** type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_