FREDERICK
GASTROENTEROLOGY
ASSOCIATES

# New Patient Intake Form

Name_________________________ Date of Birth:______________ Gender: ___________

Marital status: □ Married □ Single □ Widowed □ Divorced

Occupation__________________________

Reason for visit________________________________________________

Referred to FGA by _____________________ Primary Care Physician______________________

Other physicians involved in your care___________________________________________________

Prior GI physicians______________________________________________________________________

Preferred pharmacy (immediate scripts)__________________________________________________

Preferred mail in pharmacy____________________________________________________________

**Past Medical History** (Circle all that apply)

□ Alcohol dependence
□Ankylosing spondylitis
□ Anxiety
□ Asthma
□ Atrial fibrillation
□ Barrett's esophagus
□ Celiac disease
□ Cirrhosis
□ *Clostridium difficile* infection
□ Constipation
□ Colon cancer
□ Colon polyps
□ Congestive heart failure
□ COPD
□ Coronary artery disease
□ Crohn's disease
□ Defibrillator
□ Depression
□ Diabetes
□ Diverticulitis
□ Eczema
□ Esophageal cancer
□ End Stage Renal Disease (dialysis)
□ Fatty liver
□ GERD (reflux)
□ Heart attack
□ Hepatitis B
□ Hepatitis C
□ High Blood Pressure
□ High cholesterol
□ HIV/AIDS
□ Irritable Bowel Syndrome (IBS)
□ Irregular heartbeat
□ Kidney Disease
□ Kidney Stones
□ Liver cancer
□ Melanoma
□Nerve stimulator
□ Obesity
□ Osteoporosis
□ Pacemaker
□ Pancreatic cancer
□ Pancreatic cyst
□ Pancreatitis
□ Peptic ulcer
□ Psoriasis
□ Seizures
□Sleep apnea
□ Stomach cancer
□ Stroke
□ Thyroid disease
□ Ulcerative Colitis

Other past medical history not listed _____________________________________________

FREDERICK
GASTROENTEROLOGY
ASSOCIATES

**Past Surgical History** (check all that apply)

□ Appendectomy
□ Back surgery
□ Bowel resection
□ C-section
□ Cholecystectomy (gallbladder)
□ Coronary artery bypass (CABG)
□ Coronary stents
□ Gastric Bypass
□ Gastric Sleeve
□ Heart valve surgery
□ Hysterectomy
□ Kidney transplant
□ Liver transplant
□ Nissen fundoplication
□ Pancreas resection

Other surgeries not listed ____________________________________________________

**Prior Hospitalizations**

| Date | Location | Reason |
|---|---|---|
| | | |
| | | |
| | | |

| Endoscopic Procedures performed | Indication | Physician/location | Date |
|---|---|---|---|
| Colonoscopy | | | |
| Upper endoscopy (EGD) | | | |
| ERCP | | | |
| EUS | | | |

**Provide details regarding current and/or past use:**

Alcohol (beer, wine, liquor,etc) ☐ yes ☐no Weekly consumption _______________

Tobacco (cigarettes, cigar, chewing) ☐ yes ☐no Usage/frequency __________________

IV drugs ☐ yes ☐no Drug/frequency __________________

Recreational drugs ☐ yes ☐no Drug/frequency ___________________

Vaping ☐ yes ☐no Product/frequency________________

Marijuana (smoking/edibles) ☐ yes ☐no form/frequency________________

**Please list all medicines and supplements you currently take**

| Medicine | Dose |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| Medicine | Dose |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Medicine allergies:** ______________________________

**Immunizations:**

- ☐ COVID
- ☐ Hepatitis A/B
- ☐ Flu
- ☐ Shingles
- ☐ Tetanus
- ☐ Pneumovax
- ☐ DtaP
- ☐ HPV

| Family History | Mother | Father | Siblings | Son | Daughter |
|---|---|---|---|---|---|
| Barrett's Esophagus | | | | | |
| Cancer | | | | | |
| Breast | | | | | |
| Colon | | | | | |
| Esophagus | | | | | |
| Pancreas | | | | | |
| Stomach | | | | | |
| Bile duct | | | | | |
| Brain | | | | | |
| Ovarian | | | | | |
| Endometrial | | | | | |
| Urothelial | | | | | |
| Colon polyps | | | | | |
| Crohn's disease | | | | | |
| Ulcerative colitis | | | | | |
| Liver disease | | | | | |
| Celiac disease | | | | | |
| Lynch Syndrome | | | | | |

**Review of systems** (Did you have any of these symptoms in the past 3 months?)

Gastrointestinal

- ☐ Abdominal pain
- ☐ Anal/Rectal Pain/itching
- ☐ Black stools
- ☐ Red blood in stools
- ☐ Bloating
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Difficulty swallowing
- ☐ Heartburn/reflux
- ☐ Hemorrhoids
- ☐ Mucus in Stool
- ☐ Nausea/vomiting
- ☐ Pain with bowel movements

Cardiovascular
- □ High Blood Pressure
- □ Heart murmur
- □ Palpitations
- □ Chest Pain
- □ Leg swelling

Respiratory
- □ Chronic cough
- □ Shortness of Breath
- □ Wheezing/Asthma

Hematology
- □ Bleeding Problems
- □ Excessive Bruising
- □ Anemia

Constitutional
- □ Fatigue
- □ Loss of Appetite
- □ Night Sweats
- □ Weight Loss

Mental Health
- □ Anxiety
- □ Depression

Skin/Eyes/Mouth
- □ Itching skin
- □ Jaundice (yellow eyes/skin)
- □ Visual Changes
- □ Mouth sores/ulcers

Neurologic
- □Headache
- □Dizziness/Vertigo
- □Head Injury
- □Numbness/Weakness

Musculoskeletal
- □ Back Pain
- □ Arthritis

Genitourinary
- □ Blood in the urine
- □ Kidney Stones
- □ Urinary Tract Infection