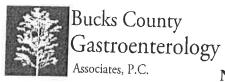


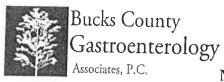
## New Patient Medical History Intake Form

Patient Information								
Date:Patient Name:			-					
REASON FOR VI	ISIT	Date of Birth:				ale 🗆 Female [		
Marital Status:	M D S W							
Occupation:			E1					
Occupation:  Spouse Name:			Emple	oyer:				
Parent/Legal Guard								
State/Country of Bi	rth:		Consis	1.0.				
Language:		Race:	Special Communication Needs:Decline   Ethnicity:Declin					
Patient Contact Int	formation –							
State:	Zin:	Country		C 1.701	City: _			
Address:State:Is this phone number	r? Cell C Uo	ma	P	referred Pho	ne Numbe	er:		
r		me - work						
May we leave detail	ied messages at t	his phone? $\square$ N						
Secondary Phone:			_ Email:	-				
<b>Emergency Contact</b>	t Information -							
Name	Name Relationship Phone I				mber Address			
I hereby authorize E information to: M	lyself Only []	astroenterology	to discuss			rotected l	health	
			Relationship		Phone			
Advanced Care Dire Have you designated	ctive - Do you h a Durable Pow	ave an Advance er of Attorney?	e Directive	e or Living \  YES If yes	Will? □	NO 🗆 YES	S mation below:	
Name	Phone Number Date							
							Date	
Specialist Contact Int	formation - (Ple	ase provide first	and last na	mae)				
	Physician N							
CP:				Office Name		L	ocation	
ardiologist:								
/necologist:								
her:								
					4			



## New Patient Medical History Intake Form

Patient I		n/Imm	ınizotio-	Ti-4	/7/		=:•			irth:			
Tiddle V2	iccinatio)		Date	Histo	ry - (li	available	please a		childh	ood imm	unizatio	ns se	eparately) Date
Hepatitis A				Z	Coster				Flu			+	Date
Hepatitis B			Shingrix						umococcal		-		
Ugalth III	indows T	Y . Tester							-	mococcar			
Health H	Ulcer	ave yo	Thyroid 1	een dia	ignose							1	
☐ Reflux D			☐ Thyroid Disorder ☐ Diabetes		Heart Disease / CAD		☐ Depression			Oth	ner Health Condition		
☐ Gall Blac						☐ Heart Attack			☐ Anxiety				
☐ Pancreati			☐ Arthritis			Heart Murmur			☐ Eating Disorder				
☐ Colitis			☐ Kidney Disease ☐ Seizures / Epilepsy			☐ Heart Failure			☐ Drug Addiction				
☐ Diverticu	litis						☐ High Cholesterol			☐ Alcoholism			
		_	☐ Parkinson's Disease			☐ Asthm				☐ Osteoporosis			
☐ Irritable E	Bowel		☐ High Blood Pressure		☐ Season	Seasonal Allergies			☐ Tuberculosis				
☐ Hepatitis			□ Stroke			☐ Sleep Apnea			☐ Anemia				
☐ Liver Dise	ease		☐ Multiple Sclerosis						☐ Bleeding Disorder				
□ Polyps			☐ Migraines/Headache					□ Bl	Blood Clot				
□ IBD Гуре:			☐ Cancer Type:			☐ Peripheral Vascular Disease		ular	☐ Autoimmune Disease Type:				
Family his	Current Age,if	dopted Age at Death		IBD	Liver Disea		Pancr- eatitis	Gallb Disea	oladder ase	Cancer	Туре		Other
ather	living					-							
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laternal													
randmother									]				
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ternal andfather									]				
oling													
oling													
her relative	- 1												



## New Patient Medical History Intake Form

Patient Name:	Da	te of Birth:					
Surgical History - None							
	Procedure						
Current Medicalia							
Current Medications with Dosages	- None 🗆						
<u> </u>							
Social history - Details Attached							
Tobacco Use:	Alcohol Consumption:   Number of drinks per week:   Preferred drink (ie: beer, wine, spirits):	Recreational Drug Use:  Type:  Amount per week:  Last used:					
QUIT Years quit:	□ QUIT Years quit:	□ QUIT Years quit:					
Caffeine: ☐ YES ☐ NO of caffeine drinks per day:	Do you use e-cigarettes, vape or other?  ☐ YES ☐ NO						
Allergies - No Known Drug Allergies [	☐ Latex: Yes ☐ No ☐						