

SOUTH SUBURBAN GASTROENTEROLOGY, PC
WEYMOUTH ENDOSCOPY, LLC

NEW PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

STREET: _____ SOC. SEC. # _____

CITY: _____ STATE: _____ ZIP: _____

MAIDEN NAME: _____ MARITAL STATUS: M _ S _ D _ W _

SPOUSES NAME: _____ EMPLOYER: _____

HOME TEL: _____ CELL TEL: _____ WORK TEL: _____

Please check all that apply:

It is OK to leave results from labs, tests and biopsies on my answering machine at my home/cell phone.

You can share results of labs, imaging tests, and biopsies with the following people:

ALLERGIES: _____



PRIMARY CARE MD: _____ REFERRING MD: _____

PRIMARY INSURANCE: _____ CERTIFICATE #: _____

SUBSCRIBER: _____ DOB: _____ EMPLOYER: _____

SECONDARY INSURANCE: _____ CERTIFICATE#: _____

I hereby authorize South Suburban Gastroenterology and/or Weymouth Endoscopy to furnish information to insurance carriers concerning my illness and treatment; and I hereby assign to the physicians all payments for medical services rendered to my dependents and/or myself. I understand that I am responsible for any amount not covered by insurance.

Signature

Date

PATIENT HISTORY FORM REVIEW OF SYSTEMS

Name: _____

Date of Birth: _____

Constitutional

Recent Weight Change ___ YES ___ NO
Fever ___ YES ___ NO
Fatigue ___ YES ___ NO

Eyes

Blurred Vision ___ YES ___ NO
Glaucoma ___ YES ___ NO

Ears/Nose/Mouth/Throat

Hearing Loss ___ YES ___ NO
Ringing in Ears ___ YES ___ NO
Mouth Sores ___ YES ___ NO

Cardiovascular

Chest Pain ___ YES ___ NO
Shortness of Breath ___ YES ___ NO
Swelling of Ankles ___ YES ___ NO

Respiratory

Chronic Cough ___ YES ___ NO
Spitting up Blood ___ YES ___ NO
Wheezing ___ YES ___ NO

Genitourinary

Burning with Urination ___ YES ___ NO
Blood in Urine ___ YES ___ NO

Musculoskeletal

Joint Pain ___ YES ___ NO
Swelling ___ YES ___ NO
Back Pain ___ YES ___ NO
Muscle Pain ___ YES ___ NO

Skin

Rash ___ YES ___ NO
Itching ___ YES ___ NO

Gastrointestinal

Poor Appetite ___ YES ___ NO
Difficulty in Swallowing ___ YES ___ NO
Heartburn ___ YES ___ NO
Nausea ___ YES ___ NO
Vomiting ___ YES ___ NO
Bloating ___ YES ___ NO
Belching ___ YES ___ NO
Regurgitation ___ YES ___ NO
Constipation ___ YES ___ NO
Diarrhea ___ YES ___ NO
Abdominal Pain ___ YES ___ NO
Recent Change in Bowel Habits ___ YES ___ NO
Rectal Bleeding ___ YES ___ NO
Black, Tarry Stools ___ YES ___ NO

Neurological

Headaches ___ YES ___ NO
Seizures ___ YES ___ NO
Numbness ___ YES ___ NO
Strokes ___ YES ___ NO

Psychiatric

Memory Loss or Confusion ___ YES ___ NO
Depression ___ YES ___ NO

Endocrine

Heat Intolerance ___ YES ___ NO
Cold Intolerance ___ YES ___ NO
Excessive Thirst ___ YES ___ NO
Excessive Urination ___ YES ___ NO

Hematological

Bleeding Tendency ___ YES ___ NO
Bruising Tendency ___ YES ___ NO
Anemia ___ YES ___ NO
Past Transfusion ___ YES ___ NO
Are you Pregnant? ___ YES ___ NO

Do you take any blood thinners? No Yes What Medication _____

Medication Allergies: _____

List of Medications and Doses: _____

Comments/Concerns:

PATIENT HISTORY FORM

Name _____ Date of Birth _____
 Race: White Asian African American Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native
 Ethnicity: Hispanic/Latino Non Hispanic/Latino Language: _____ Height: _____ Weight: _____
 Primary Care Physician: _____ Pharmacy: _____ Location: _____
 Reason for today's visit: _____

List all prior surgeries and date: _____

Circle Present and Past Medical History:

Anemia Angina Anxiety Arrhythmia Arthritis Asthma Blood Clot in Leg or Lung Bronchitis Cancer Congestive Heart Failure Constipation Crohn's Disease Depression Diabetes Elevated Cholesterol Emphysema Heart Attack Heart Murmur Hepatitis Hiatal Hernia Hypertension Irritable Bowel Syndrome Peptic Ulcer Reflux Rheumatic Fever Seizure Sleep Apnea Stroke Thyroid Disease Tuberculosis Ulcerative Colitis
 Other: _____

Have you ever had a colonoscopy before?
 No Yes
 If so, when and where? _____

Have you ever smoked? No Yes
 If currently smoking, how many packs per day? _____
 If not currently smoking, quit date: _____

Have you ever had any problems with anesthesia or sedation? No Yes
 If yes, what happened? _____

Do you drink alcohol? None Occasional Daily
 Recreational drug use? No Yes
 Marital Status: Single Married Divorced Widowed
 Do you work? No Yes Type of Work: _____

Any family history of liver disease, celiac disease, Crohn's, ulcerative colitis, other cancer? _____
 Family History Colon Polyps: No Yes Whom: _____
 Family History Colon Cancer: No Yes Whom: _____
 Family History of Other Significant Disease(s): _____

To Be Completed by Gastroenterologist on day of exam:

HPI: _____

Physical Examination:	BP _____	Hgt _____	Wgt _____	Yes	No	Comments
1. Constitutional: Well-nourished/well developed:				<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Skin: Skin free of rashes, purpura, petechiae, stigmata:				<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Eyes: Lids and Conjunctivae normal:				<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Ears/Nose/Mouth/Throat: Is the oral mucosa pink/moist				<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Hematologic/Lymphatic/Immunologic: Nodes in neck nl:				<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Respiratory: Lungs clear to auscultation:				<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Cardiovascular: Heart rate regular & no murmur:				<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Gastrointestinal: Soft, nl tympany, active bs, no hsm no masses, no tenderness				<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Musculoskeletal: No clubbing, deformities, edema of extremities				<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Rectal: Hem occult negative:				<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Neurologic: Intact				<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Psychiatric: Alert, oriented to time/person/place				<input type="checkbox"/>	<input type="checkbox"/>	_____

Reviewed By _____ Date: _____

ASA: _____

I have reassessed the patient and find no changes to the above
 Reviewed By _____ Date: _____

**WEYMOUTH ENDOSCOPY, LLC
PATIENT MEDICATION HISTORY FORM**

Name: _____ Date of Birth: _____

Date of Exam: _____

**Please mail back with packet*

Daily Medications Taken: **No** **Yes**

Allergies / Sensitivities and Reactions:

Name of Medication/Vitamin/OTC	Dose	How often taken	Last dose taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Physician Documentation:

Any changes to medication after procedure: **No** **Yes** _____

New medication added today: **No** **Yes** _____

	YES	NO	N/A	DATE
Resume Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Resume Ibuprofen, Aleve, Excedrin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Resume Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Due to your endoscopic intervention, please refrain from Aspirin and NSAID products for _____ days

MD signature: _____ **Date:** _____

Nursing Documentation: Today you had the following procedure:

Colonoscopy _____ Gastroscopy _____ Flexible Sigmoidoscopy _____

You were given the following medications:

Versed _____ Fentanyl _____ Demerol _____ Zofran _____ Other: _____

Endoclip was used today Yes - If yes and you require an MRI in the next month, please notify the Radiologist.

Nurse Signature: _____ **Date:** _____

WEYMOUTH ENDOSCOPY, LLC.

CONSENT FOR COLONOSCOPY

My physician has recommended a Colonoscopy to evaluate the following condition:

1. CONDITION

My physician has explained to me the technique of Colonoscopy, the risks and benefits of Colonoscopy, additional procedures, which may be performed during Colonoscopy and the way in which I will be sedated for my Colonoscopy. I have had an opportunity to ask any questions, discuss alternative therapies, risk and benefits and I have received appropriate responses to these questions.

2. PROCEDURE

DESCRIPTION OF COLONOSCOPY

Colonoscopy is an examination of the Colon, using a flexible scope, which will be inserted into the rectum and advanced under visual guidance throughout the entire length of the colon to its junction with the small intestine into the cecum and sometimes into the small intestine. During Colonoscopy, an image of the inside lining of the colon is portrayed on a video monitor and reviewed by my physician. This technique allows the physician a detailed examination of the lining of the bowel where pathology is most likely to occur. This technique has the ability to diagnose most of the common diseases of the colon and to exclude those diagnoses, which are of the greatest concern. Any tissue removed during Colonoscopy will be sent to a pathology laboratory where a Pathologist will review it. A colonoscopy is an imperfect exam and there is a small but real possibility that significant pathology including polyps and small cancers may be missed.

ADDITIONAL PROCEDURES:

Additional procedures are commonly performed during Colonoscopy, which include biopsies of the lining of the large bowel, Polypectomy, which is the removal of polyps and cautery of abnormal blood vessels. Sometimes dilation of stricture or tattoo of lesion site is required. These procedures are performed routinely in Colonoscopy if the appropriate pathology is identified during that examination.

3. RISKS AND BENEFITS

RISKS OF COLONOSCOPY:

The risks of Colonoscopy are rare, but may be serious and life threatening. These risks include perforation of the colon by the Colonoscope, which usually requires surgical repair. It is possible that a Colostomy may need to be performed during the repair of a perforation. Additional risks include bleeding, which is most likely to occur after removal of a polyp. Bleeding is usually self-limited, but may be serious and can possibly require transfusions and/or surgery to control. Infections, leakage of air from the bowel into the abdominal cavity are also possible complications. Additional risks associated with any invasive procedure, but not specifically associated with Colonoscopy include unanticipated bleeding, development of blood clots, tissue damage, respiratory problems, infections, and cardiovascular or pulmonary complications. **I understand that do not resuscitate directives will not be honored at this facility.**

SEDATION:

During Colonoscopy I will receive intravenous medicine for sedation. This technique may use several different medications alone or in combination, which result in the induction of a sleep like state, during which memory is often impaired. The degree of sedation varies from person to person and it is conceivable that some pain may be felt during the procedure or some discomfort remembered after the procedure. My physician is limited in the amount of medicine that can be administered by safety factors and changes in my vital signs. Complications from sedation include: Inadequate Respiration, which may require respiratory assistance or reversal of the sedative, low blood pressure, erratic or slow pulse rate, all of which may require administration of additional medications.

4. ACKNOWLEDGEMENT

I understand the need for Colonoscopy. I understand the potential benefit of the procedure and the potential risks associated with it.

5. CONSENT

I give my consent to have the procedure performed by Dr. _____.

Patient/Legal Representative

Witness

Physician Signature MD

Date

MAGNESIUM CITRATE PREPARATION: 3 BOTTLES

Purchase 3 bottles of Magnesium Citrate (not red) from any pharmacy. No prescription needed.

One week prior to procedure:

- 1- Please check with your PCP and your gastroenterologist if you take any blood thinners such as Warfarin/Coumadin, Eliquis, Xarelto, Brilinta, Pradaxa, Plavix, or Aggrenox.
- 2- Aspirin should not be held.
- 3- You may continue any NSAID's such as Ibuprofen, Motrin, Aleve, Naproxen, Diclofenac, or Indocin.
- 4- Please hold iron pills after checking with your PCP.
- 5- If you are a diabetic, check with your PCP regarding diabetic medication dosing for this procedure.

Five days prior to procedure:

- 1- Do not consume any nuts, seeds, popcorn, or corn.
- 2- Hold any fiber supplements.

Day before the procedure:

- 1- No solid foods are permitted.
- 2- Clear liquids are to be consumed all day. Please drink plenty of clear liquids throughout the day and evening. This helps to achieve a more effective preparation and prevents dehydration.
- 3- Examples of clear liquids include: Crystal Light, Gatorade, Powerade, soda, apple juice, seltzer, flavored water, black tea/coffee, Italian ice, popsicles, Jell-O and broth. No milk or cream. Avoid red color in popsicles, Italian ice, Jell-O, Gatorade, etc.
- 4- At 4:00 o'clock, drink one bottle of Magnesium Citrate.
- 5- At 6:00 o'clock, drink the second bottle of Magnesium Citrate.

Day of exam:

- 1- 4 hours prior to your exam time, drink the third bottle of Magnesium Citrate.
- 2- You may drink clear fluids up to 3 hours prior to your exam time.
- 3- No solid foods are permitted.
- 4- You may take any prescription medications.

If you have kidney disease, please call us to confirm this preparation

You must have a ride home from a family member or friend as public transportation is not allowed. You are not able to drive for the remainder of the day.

South Suburban Gastroenterology, PC
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INSURANCE WAIVER OF LIABILITY

Without a referral, your insurance may not pay for services rendered. If your insurance determines that a particular service is not covered without a referral, your insurance may deny payment for that service.

As your physician, I believe this service is medically necessary, but it may not be payable under your insurance policy. In this specific circumstance, your insurance may deny payment for this service.



I have been informed by my physician's office that I am responsible for payment of this service should my insurance company deny payment.

Signature

Date