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			Gastrointestinal		
Recent Weight Change	___YES	___NO	Poor Appetite	___YES	___NO
Fever	___YES	___NO	Difficulty in Swallowing	___YES	___NO
Fatigue	___YES	___NO	Heartburn	___YES	___NO
			Nausea	___YES	___NO
			Vomiting	___YES	___NO
Eyes			Bloating	___YES	___NO
Blurred Vision	___YES	___NO	Belching	___YES	___NO
Glaucoma	___YES	___NO	Regurgitation	___YES	___NO
			Constipation	___YES	___NO
Ears/Nose/Mouth/Throat			Diarrhea	___YES	___NO
Hearing Loss	___YES	___NO	Abdominal Pain	___YES	___NO
Ringing in Ears	___YES	___NO	Recent Change in Bowel Habits	___YES	___NO
Mouth Sores	___YES	___NO	Rectal Bleeding	___YES	___NO
			Black, Tarry Stools	___YES	___NO
Cardiovascular					
Chest Pain	___YES	___NO	Neurological		
Shortness of Breath	___YES	___NO	Headaches	___YES	___NO
Swelling of Ankles	___YES	___NO	Seizures	___YES	___NO
			Numbness	___YES	___NO
Respiratory			Strokes	___YES	___NO
Chronic Cough	___YES	___NO			
Spitting up Blood	___YES	___NO	Psychiatric		
Wheezing	___YES	___NO	Memory Loss or Confusion	___YES	___NO
			Depression	___YES	___NO
Genitourinary					
Burning with Urination	___YES	___NO	Endocrine		
Blood in Urine	___YES	___NO	Heat Intolerance	___YES	___NO
			Cold Intolerance	___YES	___NO
			Excessive Thirst	___YES	___NO
Musculoskeletal			Excessive Urination	___YES	___NO
Joint Pain	___YES	___NO			
Swelling	___YES	___NO	Hematological		
Back Pain	___YES	___NO	Bleeding Tendency	___YES	___NO
Muscle Pain	___YES	___NO	Bruising Tendency	___YES	___NO
			Anemia	___YES	___NO
Skin			Past Transfusion	___YES	___NO
Rash	___YES	___NO	Are you Pregnant?	___YES	___NO
Itching	___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/Alaskian 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 had any problems with anesthesia or sedation? ☐ No ☐ Yes
If yes, what happened? _____

Have you ever smoked? ☐ No ☐ Yes
If currently smoking, how many packs per day? _____
If not currently smoking, quit date: _____
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:	☐	☐	_____
2. Skin: Skin free of rashes, purpura, petechiae, stigmata:	☐	☐	_____
3. Eyes: Lids and Conjunctivae normal:	☐	☐	_____
4. Ears/Nose/Mouth/Throat: Is the oral mucosa pink/moist	☐	☐	_____
5. Hematologic/Lymphatic/Immunologic: Nodes in neck nl:	☐	☐	_____
6. Respiratory: Lungs clear to auscultation:	☐	☐	_____
7. Cardiovascular: Heart rate regular & no murmur:	☐	☐	_____
8. Gastrointestinal: Soft, nl tympany, active bs, no hsm no masses, no tenderness	☐	☐	_____
9. Musculoskeletal: No clubbing, deformities, edema of extremities	☐	☐	_____
10. Rectal: Hem occult negative:	☐	☐	_____
11. Neurologic: Intact	☐	☐	_____
12. Psychiatric: Alert, oriented to time/person/place	☐	☐	_____

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	☐	☐	☐	_____
Resume Ibuprofen, Aleve, Excedrin	☐	☐	☐	_____
Resume Blood Thinners	☐	☐	☐	_____

☐ 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 GASTROSCOPY

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

_____

1. CONDITION

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

2. PROCEDURE

DESCRIPTION OF GASTROSCOPY:

Gastroscopy is an examination of the Esophagus, Stomach and Duodenum, using a flexible scope, which will be inserted through the mouth and advanced under visual guidance throughout the upper gastrointestinal tract. During Gastroscopy, an image of the inside lining of the Esophagus, Stomach and Duodenum is portrayed on a video monitor and reviewed by my physician. This technique allows the physician a detailed examination of the lining of the upper gastrointestinal tract where pathology is most likely to occur. This technique has the ability to diagnose most of the common diseases affecting the upper gastrointestinal tract and to exclude those diagnoses, which are of the greatest concern.

ADDITIONAL PROCEDURES:

Additional procedures are commonly performed during Gastroscopy, which include biopsies of the surface of the Esophagus, Stomach or Duodenum, removal of polyps and cautery of abnormal blood vessels. In additional special circumstances, injection of medicines to retard bleeding from abnormal blood vessels may be required, dilation of strictures and bonding of varices. These procedures are performed routinely in Gastroscopy if the appropriate pathology is identified during that examination. Any tissue removed during Gastroscopy will be sent to a pathology department where it will be reviewed by a pathologist.

3. RISKS AND BENEFITS

RISKS OF GASTROSCOPY:

The risks of Gastroscopy are rare, but may be serious and life threatening. These risks include perforation of the Intestinal Tract, which usually requires surgical repair, bleeding, which may come from biopsy or removal of tissue. Bleeding is usually self- limited, but may be serious and can require transfusions and/or surgery to control. Infections and leakage of air from the intestinal tract into the abdominal cavity or chest cavity may occur. Additional risks associated with any invasive procedure include post procedure pain, tissue damage, bleeding, blood clots, respiratory problems and infections. Additional procedures performed during Gastroscopy, such as Esophageal Dilation may have their own complications including perforation of the Esophagus or Stomach. **I understand that do not resuscitate directives will not be honored at this facility.**

SEDATION:

During Gastroscopy I will receive intravenous medication for sedation. This technique uses several medications alone or in combination, which results in the induction of a sleep-like state, during which memory is often impaired. The degree of sedation varies and it is conceivable that some degree of pain or some discomfort may be felt during the examination. My physician is limited in the amount of medicine that can be administered by safety factors and changes in my vital signs. Complications for sedation include: inadequate respiration, which may require assistance with breathing and/or reversal of the sedation, low blood pressure, slow or erratic pulse rate, which may require additional medications to be administered.

4. ACKNOWLEDGEMENT

I understand the need for Gastroscopy. I understand the potential benefits of the procedure and the potential risks associated with it. I understand that do not resuscitate directives will not be honored at Weymouth Endoscopy.

5. CONSENT

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

_____ _____

Patient/Legal Representative Witness

_____MD _____

Physician Signature Date

South Suburban Gastroenterology, PC
Weymouth Endoscopy, LLC
1085 Main Street, South Weymouth
TEL: 781-331-2922 FAX: 781-335-5702

Instructions for Gastroscopy

Name: _____
Your procedure has been scheduled on: _____ at _____.
Please arrive at: _____

Please bring your insurance cards and a photo ID with you on the day of the procedure.
Please obtain a referral from your primary care physician if needed.

Preparation:

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- If you are a diabetic, check with your PCP regarding diabetic medication dosing for this procedure.

Day before the procedure:

1- Do not eat or drink after midnight the night before your exam.

Day of exam:

1- Continue not to eat or drink until after the procedure.
2- You may take your prescribed medications with a small sip of water.
3- Please bring in your health history form and medication list if you have not mailed them in yet.

Please call if you have questions or concerns about your procedure.

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.

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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