Digestive Disease Associates

New Patient Form

First Name Last Name

Date of Birth Gender Social Security #

Race Hispanic or Not Hispanic

Street Address City

State Zip Code

Telephone Primary Secondary

Emergency Contact First Name Last Name

Phone Number

Pharmacy

Insurance ◯ Yes ◯ No If yes, provide details below:

Insurance carrier

Member ID number Group number

Insured name DOB

Relationship

Reason for colonoscopy ◯ colon cancer screening ◯ other

◯ family history of colon cancer

◯ personal history of polyps

When was your last colonoscopy (if applicable)

Findings of your last colonoscopy (if applicable)

Personal history of colon polyps ◯ Yes ◯ No

Family history of colon cancer ◯ Yes ◯ No

If yes, who?

Family history of colon polyps ◯ Yes ◯ No

If yes, who?

Primary Cary Physician

Referring Physician

Do you see a heart specialist (cardiologist) ◯ Yes ◯ No

Medical Problems

Past Surgeries

Allergies

Medications

Do you take any blood thinners?	◯ Yes	◯ No
Do you have sleep apnea?	◯ Yes	◯ No
Do you use oxygen?	◯ Yes	◯ No
Do you have an ICD (Implantable Cardioverter Defibrillator)?	◯ Yes	◯ No
Did you have a heart attack or stroke in the last 6 months?	◯ Yes	◯ No
Are you able to move your neck side to side and up and down?	◯ Yes	◯ No
Are you on dialysis?	◯ Yes	◯ No
Do you have a bleeding disorder?	◯ Yes	◯ No
Any abdominal/bowel surgeries in the last 3 months	◯ Yes	◯ No
Any problems with anesthesia?	◯ Yes	◯ No

Height Weight BMI

Do you have chronic abdominal pain? Yes No

Do you have heartburn? Yes No

Do you have trouble swallowing? Yes No

Do you see blood in your stool or in the toilet? Yes No

Do you have constipation or diarrhea? Yes No