# Digestive Disease Associates

## New Patient Form

First Name: Last Name:

Date of Birth: Gender: Social Security #:

Race:

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 |

## Social History

Do you smoke? How much?
Do you drink? How much?
Hx of Drug Abuse?