Stanley P. Weiselberg, M.D.
Norman R. Neslin, M.D.
Robert R. Pavelock, M.D.
Bradley F. Sklar, M.D.

Richard M. Cherpak, M.D.
Emil P. Miskovsky M.D.
Harvey H. Allen, M.D.
Mark M. Pinkhasov, D.O. PharmD

Name: _____ **Age:** _____ **Date:** _____

Account #: _____ **Date of Birth:** _____

Problem for which you are seeking attention:

How long have you had this problem?

Have you seen a doctor, and if so, how did he/she treat this problem?

Was the treatment effective?

Past hospitalizations and/or surgeries?

Alcohol use: _____ Smoking: _____

Allergies: _____

Check any of the following that you have trouble with:

❑ Swallowing
❑ Food gets stuck
❑ Vomiting
❑ Bleeding
❑ Change in skin color
❑ Change in urine color
❑ Change in stool color
❑ Upper abdominal pain
❑ Lower abdominal pain
❑ Right-sided abdominal pain
❑ Left-sided abdominal pain
❑ Diarrhea
❑ Nausea
❑ Heartburn
❑ Excessive gas
❑ Jaundice
❑ Liver trouble
❑ Gallbladder trouble
❑ Ulcers
❑ Hepatitis
❑ Pancreas
❑ Bowels

Do you have or have you had:

❑ Diabetes mellitus
❑ Angina
❑ Tuberculosis
❑ High blood pressure
❑ Shortness of breath
❑ VRE
❑ Stroke
❑ MRSA
❑ C-Diff

Have you ever had a colonoscopy, and if so, where, when and why?

Name: _____ **Date of Birth:** _____

Account #: _____

Have you have had a gastroscopy, and if so, where, when and why?

Have you ever had Anesthesia for any reason in the past? Yes No

Did you ever experience any difficulties with Anesthesia? Yes No

If YES, please describe _____
_____
_____
_____

Family history (if deceased, list age and cause; if alive, list major illnesses)

Father
Mother
Brother(s)
Sister(s)
Other(s)

MEDICATIONS: Please list all medications on this side or bring a list with you.