DEPARTMENT OF MEDICINE

Gastroenterology and Hepatology Division

UR MEDICINE

MEDICINE *of* THE HIGHEST ORDER

Welcome to our Practice!

Enclosed please find our New Patient Forms.

Please complete the **New Patient Questionnaire** attached to the best of your abilities and bring it with you to your appointment.

With: _____ on: _____ Time: _____

We have multiple sites; please report to the marked location.

□ Gastroenterology & Hepatology Division
180 Sawgrass Dr.
Suite 230
Rochester, NY 14620
(585) 275-4711

□ Gastroenterology & Hepatology Division
601 Elmwood Ave
Silver Elevators to the 4th Floor
Rochester, NY 14642
(585) 275-4711

Important information about insurance:

Not all insurances cover all visits/procedures. It is important that you check with your insurance carrier prior to your appointment to ensure that your visit/procedure will be covered. **Please note that you will be financially responsible for any unpaid balances.** When you arrive for your appointment, you may be asked to sign a Waiver Agreement or an Advance Beneficiary Notice (ABN). Signing this form means you are responsible for any costs of services provided which are not covered by your insurance carrier. **Your copay is due at the time of service**. Please call the number listed on your insurance card if you have additional questions about coverage.

When checking in for your appointment:

As of August 1, 2009, we are asking all patients to show photo ID when checking in for their appointments in order to comply with new federal regulations designed to protect patients from identity theft. Medical identity theft is a growing problem across the United States with over 250,000 cases each year. We greatly appreciate your cooperation and thank you for partnering with us to assure that we provide you and your loved ones with exceptional care. If you have any concerns about this policy, please call the Integrity Hotline at (585) 756-8888.

601 Elmwood Avenue • Box 646 • Rochester, NY 14642
585-275-4711 • 585-276-0101 *fax* • 585-271-7868 *fax* • 585-276-1911 *fax*
www.gastro.urmc.edu • gastro_hep@urmc.rochester.edu *e-mail*

STRONG MEMORIAL HOSPITAL

DIGESTIVE DISEASE UNIT
PATIENT QUESTIONNAIRE
SMH 1334 MR

180

☒ Outpatient

Please fill out all items in this form as completely as possible.

Name: _____ Date of Visit: _____ Gender: Male Female

Referring Care Provider: _____ Primary Care Provider (if different): _____

Briefly explain the reason you were referred to the Gastroenterologist: _____

Have you seen another Gastroenterologist in the past? ☐ Yes ☐ No If yes, advise name(s): _____

Please answer the following questions:

☐ Yes ☐ No 1. Have you had a recent change in your appetite?
☐ Yes ☐ No 2. Do you have difficulty swallowing food or liquids?
☐ Yes ☐ No 3. Does indigestion or heartburn trouble you?
☐ Yes ☐ No 4. Do you often have stomach problems?
☐ Yes ☐ No 5. Have you had a recent change in your bowel pattern?
☐ Yes ☐ No 6. Do you often have constipation or diarrhea?
☐ Yes ☐ No 7. Do you have black stools, or see bright red blood in stool?
☐ Yes ☐ No 8. Have you had any recent change in your weight?
☐ Yes ☐ No 9. Have you had a flexible sigmoidoscopy or colonoscopy?

Social History:

Are you: ☐ Single ☐ Married ☐ Widowed ☐ Divorced # of children (if applicable) _____

What is your occupation: _____

Have you ever used tobacco products? ☐ Yes ☐ No

If yes, what type: ☐ cigarettes _____ # of packs/day _____ # of years
☐ cigars _____ # per day _____ # of years
☐ chewing tobacco _____ per day _____ # of years

Have you quit? ☐ Yes ☐ No If yes, when: _____

Do you drink alcohol? ☐ Yes ☐ No

Type: _____ Amount: _____

Have you ever used recreational or street drugs? ☐ Yes ☐ No

Have you quit? ☐ Yes ☐ No If no, I use _____ how often _____

Caffeine ☐ Yes ☐ No If yes, I use _____
How often _____

What kind of exercise do you do and how often? _____

Describe Any Past Surgeries/Year of Surgery:

☐ Have never had surgery

Family History: Do you have blood relatives with these medical problems? Please specify the relation.

YES	NO		Relation
☐	☐	Colon Cancer or Polyps	
☐	☐	Other Cancers, Specify	
☐	☐	Heart Disease, Diabetes Mellitus, Lung disease, Hypertension	
☐	☐	Crohn's Disease or Ulcerative Colitis	
☐	☐	Others, specify	

Allergies to drugs, food, herbs, or latex / Specify allergy, and list type of reaction: ☐ None _____

See Reverse Side →

Rev. 10/05

STRONG MEMORIAL HOSPITAL

DIGESTIVE DISEASE UNIT
PATIENT QUESTIONNAIRE

SMH 1334 MR

Current Medications ***(including prescription medications and over-the-counter drugs such as aspirin, vitamins and herbs):***

	Medication Name	Dose	How Often	Reason for taking it
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Are you being treated for any health problems associated with the areas listed below?

YES	NO		Specify
☐	☐	Recent fever, chills, sweats or weakness	
☐	☐	Seizures, stroke, or other neurologic disease	
☐	☐	Vision, or hearing problems	
☐	☐	Hypertension or heart attack	
☐	☐	Chest pain, palpitations, valve disease, or murmur	
☐	☐	Coronary artery disease, congestive heart failure	
☐	☐	Dizziness	
☐	☐	Asthma, shortness of breath, or emphysema	
☐	☐	Kidney, urinary bladder or prostate problems	
☐	☐	Blood in urine, or burning on urination	
☐	☐	Liver disease	
☐	☐	Gynecological problems	
☐	☐	Diabetes, Thyroid disease	
☐	☐	Skin rash, hives or eczema	
☐	☐	Arthritis, muscle or joint aches	
☐	☐	Depression, anxiety, other psychiatric problems	
☐	☐	Bleeding problems, bruises	
☐	☐	HIV/AIDS	

Filled out by: _____ **Date:** _____

Please bring this form with you on the day of your appointment. Thank you!

Reviewed by: _____ **Date:** _____

Signature/Title