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WPPA of New Rochelle
Gastroenterology
1296 North Avenue, 2nd Floor
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Patient Demographics

Patient's Last Name First Name Middle Initial

SSN Date of Birth Age Gender F M

Address Apt. # City State Zip

Race:

- American Indian/Alaska Native Asian White
Black/African American Native Hawaiian/Pacific Islander Decline to Answer

Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline to Answer Preferred Language:

Marital Status: Single Married Divorced Widowed Separated Student Status FT PT

Home Phone Day Phone

Email Address Cell Phone

Employer Occupation Retired?

Employer Address

Emergency Contact Name Relationship Phone

Primary Care Physician Name: Phone:

Referring Physician Name: Phone:

Pharmacy Name: Phone:

Pharmacy Address:

Primary Insurance Coverage:

Policy Holder Name: SSN: DOB:

Secondary Insurance Coverage:

Policy Holder Name: SSN: DOB:

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature Date

Responsible Party Name Relationship

Patient History Form

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

Reason for Visit:

Please List All Current Medications **Not Currently Taking Any Medications**

| Medication Name | Dosage | How Often Taking | Medication Name | Dosage | How Often Taking |
|-----------------|--------|------------------|-----------------|--------|------------------|
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Allergies (e.g. medication, latex, egg) **No Known Allergies**

| Allergen | Type of Reaction | Allergen | Type of Reaction |
|----------|------------------|----------|------------------|
| | | | |
| | | | |
| | | | |

Past Medical History

| | | |
|--|--|---|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Leg/Foot Ulcers |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Has Pacemaker | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Clots (or DVT) | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Reflux Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Diabetes- insulin | <input type="checkbox"/> HIV or AIDs | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes- Non-insulin | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Overactive Thyroid | <input type="checkbox"/> Other |
| | | |

Cancer History

| Cancer Type | Year Diagnosed | Treatment (e.g. chemo, radiation) | Year Treated |
|-------------|----------------|-----------------------------------|--------------|
| | | | |
| | | | |
| | | | |
| | | | |

Patient Name: _____ Date of Birth: _____

| Past Surgical History | | |
|---|------|--|
| Please list all past surgical procedures: | | <input type="checkbox"/> No Surgical History |
| Surgical Procedure | Year | Surgeon |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Patient Name: _____ Date of Birth: _____

| FAMILY HISTORY | | | |
|---|---|--|--|
| <input type="checkbox"/> No family health information | | <input type="checkbox"/> Unknown/Adopted | |
| Relation | Alive? | Age | Significant Health History |
| Grandmother <i>(maternal)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer: _____ |
| Grandfather <i>(maternal)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer: _____ |
| Grandmother <i>(paternal)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer: _____ |
| Grandfather <i>(paternal)</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer: _____ |
| Mother | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer: _____ |
| Father | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer: _____ |
| Brother/Sister | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer: _____ |
| Brother/Sister | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer: _____ |
| Other: | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Alcoholism <input type="checkbox"/> Depression <input type="checkbox"/> Genetic Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer: _____ |

Patient Name: _____ Date of Birth: _____

Social History

Smoking Status:

Smoking Tobacco Use History (all patients age 13 and older):

Never Smoker

Current Every Day Smoker

Former Smoker

Current Some Day Smoker

Unknown if Ever Smoker

Smoker Current Status Unknown

If there is a history of tobacco use:

Years Used: _____

Usage Per Day: _____

Age Stopped: _____

Alcohol & Caffeine Use:

Do You Consume Alcohol? No Yes Former Frequency: _____ Amount: _____

Do You Consume Caffeine? No Yes Type: _____ Caffeine per day: _____

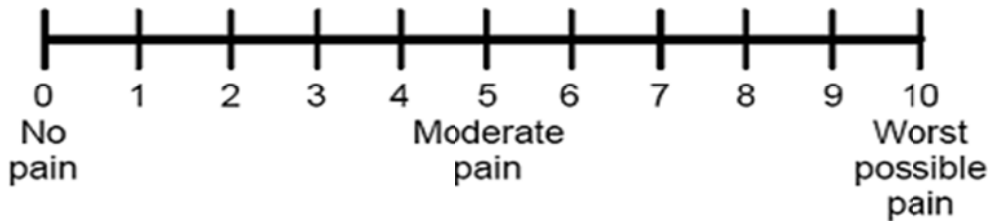
Fall Risk:

Have you had any falls in the last year? Yes No If Yes, please state the number of falls: _____

Did the fall(s) result in injury? Yes No

Pain Scale:

Please indicate (circle) your current pain scale in relation to your current condition:



Patient Signature: _____ Date: _____

Patient Representative Signature: _____ Relationship: _____