



White Plains Gastroenterology  
311 North Street, Suite 403  
White Plains, NY 10605

Robert Antonelle, M.D.

### 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 \_\_\_\_\_ / \_\_\_\_\_ Phone \_\_\_\_\_  
Name Relationship

**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			<input type="checkbox"/> Not Currently Taking Any Medications		
Medication Name	Dosage	How Often Taking	Medication Name	Dosage	How Often Taking

Allergies (e.g. medication, latex, egg)		<input type="checkbox"/> 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 / GERD	<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"/>	COPD	<input type="checkbox"/>	Overactive Thyroid (hyper)	<input type="checkbox"/>	Other
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Underactive Thyroid (hypo)	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Hepatitis				

Female Patients: # of Children \_\_\_\_\_ / # of C-sections: \_\_\_\_\_ / # of Normal Deliveries: \_\_\_\_\_

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

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please list any dietary restrictions: \_\_\_\_\_  None

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

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):

- |   |  |
|---|--|
| <input type="checkbox"/> Never Smoker           | <input type="checkbox"/> Current Every Day Smoker      |
| <input type="checkbox"/> Former Smoker          | <input type="checkbox"/> Current Some Day Smoker       |
| <input type="checkbox"/> Unknown if Ever Smoker | <input type="checkbox"/> Smoker Current Status Unknown |

If there is a history of tobacco use:

Years Used: \_\_\_\_\_

Usage Per Day: \_\_\_\_\_

Age Stopped: \_\_\_\_\_

### Alcohol Use:

Do You Consume Alcohol?  No  Yes  Former Frequency: \_\_\_\_\_ Amount: \_\_\_\_\_

### 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

### Lifestyle:

Sexual Preference:  heterosexual  homosexual  bisexual

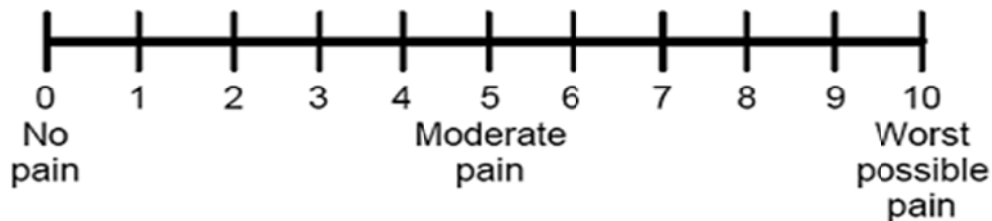
### Advance Directives:

Do you have any Advance Directive documents?  Yes  No

(e.g. living will, power of attorney, do not resuscitate (DNR) orders)

### Pain Scale:

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



Cardiologist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Representative Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_