



Weill Cornell Medicine

Gastroenterology & Hepatology

New Patient Medical History Form

Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY.**

Patient Name:		Date of Visit:	
Date of Birth:	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Preferred Phone:		Best time to call:	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Email:		Social Security Number:	
Address:		Emergency Contact (Name and Number):	
Preferred Language:		Do you need a translator the day of your visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner		Spouse/Significant Other:	
Employer:		Occupation:	
INSURANCE CARRIER:		INSURANCE ID #:	
Does your insurance plan require referrals for specialty visits? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, do you have a referral for today's visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Physician and Pharmacy Information	
Primary Care Provider (Name/Phone/Fax Number):	Preferred Pharmacy (Name/Phone/Fax Number/Address):
Referring Physician (Name/Phone/Fax Number): <input type="checkbox"/> Same as PCP	Other Physician to send records to (Name/Phone/Fax Number):
Specialty:	Specialty:
Other Physician to send records to (Name/Phone/Fax Number):	Other Physician to send records to (Name/Phone/Fax Number):
Specialty:	Specialty:

Reason/s For Visit:

How did you hear about us?

Physician Family/Friend Internet Health Plan Advertisement Referral Service Weill Cornell Connect Int'l Office

Medical History		
Please include all medical problems even if not relevant to this visit. If no medical problems, write none.		
Current or Past Medical Problems/Conditions	Dates	Reasons

Allergies (Medication, Food, Cosmetics, Etc.)	Cause/Nature of Reaction

Medications/Supplements	Dosage/Frequency	Condition/Reason

Have you taken any **aspirin, Advil, Nuprin** (NSAIDs) in the last 7 days? Yes (if so, what medication? _____) No

Hospitalizations/Surgeries	Dates	Reason
Date of most recent colonoscopy/endoscopy:	Date of most recent flu shot:	Date of most recent pneumonia shot (age 65+):

Please check the boxes below to indicate if you have experienced any of the following problems with prior surgery or anesthesia (you may select more than one):

Severe Nausea/Vomiting
 Problems Placing Breathing Tube
 Nerve Injury
 Slow Wake Up After Anesthesia
 Personal/Family History of Malignant Hyperthermia
 Other: _____

IMPLANTS: (please bring your wallet card if you are having a procedure)

Do you have a pacemaker or internal defibrillator? Yes No Do you have an artificial heart valve? Yes No

Brand? _____ Last Check-Up? _____
 Biologic Valve Mechanical Valve

Do you have any implantable devices? PICC Broviac Dialysis Catheter Fistula Ventricular Device Insulin Pump

Other: _____

Family and Social History			
Family History: Mother	Family History: Father	Family History: Siblings	Family History: Children
<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer (Type: _____) <input type="checkbox"/> Other: _____

Do you drink alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Yes. I drink <input type="checkbox"/> wine <input type="checkbox"/> beer <input type="checkbox"/> liquor <input type="checkbox"/> I have _____ drink(s) per week <input type="checkbox"/> I used to drink but quit in _____ (year)	Do you smoke? <input type="checkbox"/> I never smoked <input type="checkbox"/> Yes. I smoke <input type="checkbox"/> cigarettes <input type="checkbox"/> cigars <input type="checkbox"/> pipes. <input type="checkbox"/> I currently smoke and I don't want to quit <input type="checkbox"/> I currently smoke but I'm ready to quit. <input type="checkbox"/> I smoke _____ pack(s) per day for _____ years <input type="checkbox"/> I used to smoke but quit in _____ (year) <input type="checkbox"/> I use chewing or smokeless tobacco	Do you use recreational drugs? <input type="checkbox"/> Never <input type="checkbox"/> No, but I have used _____ <input type="checkbox"/> Yes, I use _____
Do you eat or drink foods containing caffeine ? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you exercise ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often and what type?	

Communication Consent

I hereby authorize the physician and/or the staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

- Home Telephone/Answering Machine
 Work Telephone
 Cell Phone/Voicemail
 Email
 Regular Mail

List of Authorized people that can received your medical information (*other than medical professionals listed on page 1*)

Name: _____ Relation: _____ Tel: _____

Name: _____ Relation: _____ Tel: _____

Name: _____ Relation: _____ Tel: _____

Please answer the following questions by checking the appropriate box	Yes	No
Have you ever had a heart attack or cardiac bypass operation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have stents in any artery in your brain or body?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with congestive heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have atrial fibrillation or atrial flutter?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get short of breath or have chest pain when you walk up 1 flight of stairs or 2 city blocks?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have COPD or Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a rescue inhaler (Albuterol) more than twice a week?	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalized for COPD/Asthma attack?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use supplemental oxygen at home?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed or suspected to have Obstructive Sleep Apnea (OSA)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use a BiPAP or CPAP machine at home?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble lying flat on your back?	<input type="checkbox"/>	<input type="checkbox"/>
If yes: <input type="checkbox"/> because of pain <input type="checkbox"/> because of breathing difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Do you have abnormal kidney function?	<input type="checkbox"/>	<input type="checkbox"/>
Are you on Dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take insulin?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have <input type="checkbox"/> HIV? <input type="checkbox"/> Hepatitis A? <input type="checkbox"/> Hepatitis B? <input type="checkbox"/> Hepatitis C?		
Have you been diagnosed with cirrhosis?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stroke or surgery on your carotid arteries?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any chronic pain that requires daily medication?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had chemotherapy for cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had radiation to your neck or throat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a tracheostomy (an incision in windpipe for breathing)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble opening your mouth or looking up at the ceiling?	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled outside of the US in the last two months? Where? _____		
Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an objection to blood transfusion if medically necessary?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with a bleeding disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with excessive bleeding after surgical or dental procedures?	<input type="checkbox"/>	<input type="checkbox"/>
If you are a woman of childbearing age, are you or do you believe you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Review of Systems

Please check 'YES' or 'NO' for EACH item

Constitutional

- Normal
Y N
 Fever
 Chills
 Night sweats
 Weight loss/gain
 Sleep disturbance
 Fatigue
 Poor appetite

Eyes

- Normal
Y N
 Contact lenses or glasses
 Type: _____
 Blurry vision
 Glaucoma
 Cataracts
 Retinal detachment
 Macular degeneration
 Blindness
 Redness
 Tearing
 Dryness
 Double Vision
 Discharge
 Pain

Ear

- Normal
Y N
 Hearing loss
 Hearing aids
 Wax
 Ear pain
 Ringing/noise/tinnitus
 Previous ear surgery
 Loud noise exposure

Respiratory

- Normal
Y N
 Asthma
 Emphysema/COPD
 Bronchitis
 Pneumonia
 Aspiration
 Tracheotomy
 Tuberculosis
 Coughing blood
 Shortness of breath
 Wheezing
 Cough over 3 months
 Pulmonary embolus

Nose

- Normal
Y N
 Congestion
 Mucus
 Post nasal drip
 Sinus infection
 Sinus headaches
 Nose Bleeds

Allergy

- Normal
Y N
 Sneezing
 Runny Nose
 Itchy ears, eyes, or nose
 Transplant
 Hives

Throat

- Normal
Y N
 Voice problems
 Swallowing problems
 Throat Pain
 Phlegm
 Feeling of something stuck
 Tonsil infections/problems

Sleep

- Normal
Y N
 Snoring
 Sleep Apnea
 CPAP/BiPAP/AutoPAP
 Insomnia
 Choking/Gasping
 Restless leg
 Daytime sleepiness

Gastrointestinal

- Normal
Y N
 Diarrhea
 Constipation
 Blood in stool
 Vomiting/nausea
 Ascites
 Heartburn/acid reflux
 Abdominal pain
 Ulcers
 Diverticulitis
 IBD
 Hepatitis
 Gallstones
 Pancreatitis
 Jaundice
 Cirrhosis

Endocrine

- Normal
Y N
 Diabetes
 Thyroid problems
 Autoimmune disease
 Type: _____
 Immune deficiency
 Excessive thirst
 Swollen lymph nodes
 Cold/heat intolerance
 Gout

Neurologic/Neuromuscular

- Normal
Y N
 Headaches/migraines
 Encephalopathy
 Seizures
 Tremors
 Numbness
 Stroke
 Imbalance/vertigo
 Lightheaded/fainting
 Memory loss
 Unexplained weakness

Hematologic

- Normal
Y N
 Bruise easily
 Anemia
 Leukemia/Lymphoma
 Blood clots
 Bleeding disorders
 History of radiation

Oral/Dental

- Normal
Y N
 Dentures/implants
 Temporomandibular joint
 Teeth clenching/grinding
 Tongue problems
 Mouth lesions

Genitourinary

- Normal
Y N
 Frequent urination
 Prostate problems
 Urine/bladder infections
 Yeast infections
 Incontinence
 Kidney problems/stones
 Dialysis
 Transplant

Skin

- Normal
Y N
 Past skin cancer
 Type: _____
 Skin biopsy
 Site: _____
 Eczema
 Rash or skin sensitivity
 Abnormal skin moles
 History of skin disease
 Hair loss/growth
 Itching
 Keloid scars

Musculoskeletal

- Normal
Y N
 Neck pain
 Arthritis
 Back pain/spinal problems
 Fractures
 Muscle pain
 Swelling
 Joint/bone pain

Cardiovascular

- Normal
Y N
 Heart attack
 High blood pressure
 High cholesterol
 Stents
 Coronary artery disease
 Irregular heart beat
 Chest pains
 Leg swelling
 Pacemaker/defibrillator

Psychiatric

- Normal
Y N
 Anxiety
 Depression
 Bi-polar
 Psychosis

Men's/Women's Health

- Normal
Y N
 Sexual problems
 Genital lesions
 Enlarged prostate (BPH)
 Abnormal discharge
 Cancer
 Type: _____

Any other comments/problems/concerns:

The information is accurate and complete to the best of my knowledge.

I will not hold the physician or his staff responsible for any error or omission that I may have made completing this form.

Patient Signature:

Name of person completing form (if not patient):

Today's Date:

Signature: