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:*** ❑ Male ❑ Female	
Preferred Phone:		***Best time to call:***	***May we leave a message?*** ❑ Yes ❑ No
Preferred Email:		Social Security Number:	
Address:		***Emergency Contact (Name and Number):***	
Preferred Language:		***Do you need a translator the day of your visit?*** ❑ Yes ❑ No	
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Domestic Partner		Spouse/Significant Other:	
Employer:		Occupation:	
INSURANCE CARRIER:		**INSURANCE ID #:**	
Does your insurance plan require referrals for specialty visits? ❑ Yes ❑ No		If YES, do you have a referral for today's visit? ❑ Yes ❑ 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): ❑ 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 boxers 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 Brand? _____ Last Check-Up? _____	Do you have an artificial heart valve? ❑ Yes ❑ No ❑ 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**
❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:

Do you drink **alcohol**?	Do you **smoke**?	Do you use recreational **drugs**?
❑ Never ❑ Yes. I drink ❑ wine ❑ beer ❑ liquor ❑ I have _____ drink(s) per week ❑ I used to drink but quit in _____ (year)	❑ I never smoked ❑ Yes. I smoke ❑ cigarettes ❑ cigars ❑ pipes. ❑ I currently smoke and I don't want to quit ❑ I currently smoke but I'm ready to quit. ❑ I smoke _____ pack(s) per day for _____ years ❑ I used to smoke but quit in _____(year) ❑ I use chewing or smokeless tobacco	❑ Never ❑ No, but I have used _____ ❑ Yes, I use _____

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

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: