SOUTH SUBURBAN GASTROENTEROLOGY, PC
WEYMOUTH ENDOSCOPY, LLC

NEW PATIENT INFORMATION

NAME:________________________________ DATE OF BIRTH:__________________

STREET:_______________________________SOC. SEC. # _______________________

CITY:______________________ STATE:______ZIP:___________________________

MAIDEN NAME:______________________ MARITAL STATUS: M__S__D__W__

SPOUSES NAME:____________________ EMPLOYER:_______________________

HOME TEL:_____________CELL TEL:________________WORK TEL:___________
Please check all that apply:
□ It is OK to leave results from labs, tests and biopsies on my answering machine at my home/cell phone.

□ You can share results of labs, imaging tests, and biopsies with the following people:
____

ALLERGIES: ____
♦♦♦

PRIMARY CARE MD:___________________ REFERRING MD:_________________

PRIMARY INSURANCE:___________________CERTIFICATE #:________________

SUBSCRIBER:______________ DOB:______________EMPLOYER:______________

SECONDARY INSURANCE:___________________CERTIFICATE#:_____________

I hereby authorize South Suburban Gastroenterology and/or Weymouth Endoscopy to furnish information to insurance carriers concerning my illness and treatment; and I hereby assign to the physicians all payments for medical services rendered to my dependents and/or myself. I understand that I am responsible for any amount not covered by insurance.

_____________________________ _____________________________

SIGNATURE DATE

SOUTH SUBURBAN GASTROENTEROLOGY
WEYMOUTH ENDOSCOPY, LLC

REVIEW OF SYSTEMS

Please answer all questions below
This will become a part of your medical record

Your Name:_____
Date of Birth:_____

Constitutional

Recent Weight Change	___YES ___ NO
Fever	___YES ___ NO
Fatigue	___YES ___ NO

Eyes

Blurred Vision	___YES___ NO
Glaucoma	___YES ___ NO

Ears/Nose/Mouth/Throat

Hearing Loss	___YES___ NO
Ringing in Ears	___YES ___ NO
Mouth Sores	___YES___ NO

Cardiovascular

Chest Pain	___YES___ NO
Shortness of Breath	___YES___ NO
Swelling of Ankles	___YES___ NO

Respiratory

Chronic Cough	___YES___ NO
Spitting up Blood	___YES___ NO
Wheezing	___YES___ NO

Genitourinary

Burning with Urination	___YES___ NO
Blood in Urine	___YES___ NO

Musculoskeletal

Joint Pain	___YES____NO
Joint Swelling	___YES___ NO
Back Pain	___YES___ NO
Muscle Pain	___YES___ NO

Skin

Rash	___YES___ NO
Itching	___YES___ NO

Gastrointestinal

Poor Appetite	___YES___NO
Difficulty in Swallowing	___YES___NO
Heartburn	___YES___NO
Nausea	___YES___NO
Vomiting	___YES___NO
Bloating	___YES___NO
Belching	___YES___NO
Regurgitation	___YES___NO
Constipation	___YES___NO
Diarrhea	___YES___NO
Abdominal Pain	___YES___NO
Recent Change in Bowel Habits	___YES___NO
Rectal Bleeding	___YES___NO
Black, Tarry Stools	___YES___NO

Neurological

Headaches	___YES___NO
Seizures	___YES___NO
Numbness	___YES___NO
Strokes	___YES___NO

Psychiatric

Memory Loss or Confusion	___YES___NO
Depression	___YES___NO

Endocrine

Heat Intolerance	___YES___NO.
Cold Intolerance	___YES___NO
Excessive Thirst	___YES___NO
Excessive Urination	___YES___NO

Hematological

Bleeding Tendency	___YES___NO
Bruising Tenency	___YES___NO
Anemia	___YES___NO
Past transfusion	___YES___NO
Are you Pregnant?	___YES___NO

COMMENTS/CONCERNS:

_____

_____

_____

_____

Please complete both sides of this form

PATIENT HISTORY FORM Date of Birth_____

Date: _____ Name:_____

Race: Asian White African American Unreported Ethnicity: Hispanic/latino Non Hispanic/latino Unreported

Language:_____ Height:_____ Weight:_____

Primary Care Physician: _____Pharmacy: _____ Location:_____

Reason for today's visit:_____

LIST **ALL** PRIOR SURGERIES AND DATES:_____

_____

List any Past or Present Medical Illnesses (please circle): Hypertension Heart Attack Angina Arrhythmia Congestive Heart Failure Heart Murmur Elevated Cholesterol Diabetes Anemia Arthritis Blood Clot in Leg or Lung Seizure Stroke Hepatitis Tuberculosis Cancer Asthma Bronchitis Emphysema Rheumatic Fever Thyroid Disease Peptic Ulcer Hiatal Hernia Ulcerative Colitis Crohn's Disease Irritable Bowel Syndrome Sleep apnea

Other: _____

Do you have any allergies to Medication? _____ Have you ever smoked? ☐ No ☐ Yes

_____ If currently smoking, how many packs per day? __

_____ If not currently smoking, quit date: _____

List Names of Medications you are taking: (include aspirin _____

And herbal meds) Do you drink alcohol? ☐None ☐Occasional ☐Daily

_____ Recreational drug use? ☐ No ☐ Yes

_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

_____ Age: _____ ☐ Female ☐ Male # Children _____

_____ Do you work? ☐ No ☐ Yes Type of Work:_____

_____ If retired, Occupation Before Retirement:_____

Family History of Colon Polyps: ☐ No ☐ Yes Whom:_____ # of Siblings(Alive or Deceased) _____

Family History of Colon Cancer: ☐ No ☐ Yes Whom:_____

Other Significant Disease(s) in your family:_____

Any **Family** History of liver disease, celiac disease, Crohn's, ulcerative colitis, other cancer ?_____

Have you ever had any problems with anesthesia or sedation? _____

To Be Completed by Gastroenterologist on day of exam:

HPI:_____

_____

_____

_____

_____

_____

Physical Examination: BP_____ Hgt_____Wgt_____	**Yes**	**No**	**Comments**
1. Constitutional: Well nourished/well developed:	_____	_____	_____
2. Skin: Skin free of rashes, purpura, petechiae, stigmata:	_____	_____	_____
3. Eyes: Lids and Conjunctivae normal:	_____	_____	_____
4. Ears/Nose/Mouth/Throat: Is the oral mucosa pink/moist	_____	_____	_____
5. Hematologic/Lymphatic/Immunologic: Nodes in neck nl:	_____	_____	_____
6. Respiratory: Lungs clear to auscultation:	_____	_____	_____
7. Cardiovascular: Heart rate regular & no murmur:	_____	_____	_____
8. Gastrointestinal: Soft, nl tympany, active bs, no hsm,	_____	_____	_____
no masses, no tenderness	_____	_____	_____
9. Musculoskeletal: No clubbing, deformities, edema of extremities	_____	_____	_____
10. Rectal: Hem occult negative:	_____	_____	_____
11. Neurologic: Intact	_____	_____	_____
12. Psychiatric: Alert, oriented to time/person/place	_____	_____	_____

Reviewed By_____ Date:_____

ASA: _____

I have reassessed the patient and find no changes to the above

Signed: Date:

WEYMOUTH ENDOSCOPY, LLC
PATIENT MEDICATION HISTORY FORM

Name:_____Date of Birth:_____

Date:_____
Please Complete the Medication and allergy section of this form. Please bring it with you on the date of your procedure

ALLERGIES and REACTIONS:

_____
_____

Name of Medication/Vitamin/OTC	Dose	How often taken	Last dose taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Physician Documentation:

Any changes to medication after procedure: **No ☐ Yes ☐** _____\

Resume aspirin, ibuprofen, aleve, Excedrin or any aspirin product in _____ days

New medication added today: **No ☐ Yes ☐** _____

MD signature:_____ Date:_____

Nursing Documentation:

Today you had the following procedure: ____Colonoscopy ____Gastroscopy ____Flexible Sigmoidoscopy

You were given the following medications: _____Versed_____Fentanyl_____Demerol
other:_____Endoclip was used today No ☐ Yes ☐ - If yes and you require an MRI in the future please notify the Radiologist

Nurse Initial:_____ Date:_____

WEYMOUTH ENDOSCOPY, LLC.

CONSENT FOR COLONOSCOPY

My physician has recommended a Colonoscopy to evaluate the following condition:

_____

1. **CONDITION**

My physician has explained to me the technique of Colonoscopy, the risks and benefits of Colonoscopy, additional procedures, which may be performed during Colonoscopy and the way in which I will be sedated for my Colonoscopy. I have had an opportunity to ask any questions, discuss alternative therapies, risk and benefits and I have received appropriate responses to these questions.

2. PROCEDURE: DESCRIPTION OF COLONOSCOPY

Colonoscopy is an examination of the Colon, using a flexible scope, which will be inserted into the rectum and advanced under visual guidance throughout the entire length of the colon to its junction with the small intestine into the cecum and sometimes into the small intestine. During Colonoscopy, an image of the inside lining of the colon is portrayed on a video monitor and reviewed by my physician. This technique allows the physician a detailed examination of the lining of the bowel where pathology is most likely to occur. This technique has the ability to diagnose most of the common diseases of the colon and to exclude those diagnoses, which are of the greatest concern. Any tissue removed during Colonoscopy will be sent to a pathology laboratory where a Pathologist will review it. A colonoscopy is an imperfect exam and there is a small but real possibility that significant pathology including polyps and small cancers may be missed.

ADDITIONAL PROCEDURES:

Additional procedures are commonly performed during Colonoscopy, which include biopsies of the lining of the large bowel, Polypectomy, which is the removal of polyps and cautery of abnormal blood vessels. Sometimes dilation of stricture or tattoo of lesion site is required. These procedures are performed routinely in Colonoscopy if the appropriate pathology is identified during that examination.

3. RISKS AND BENEFITS

RISKS OF COLONOSCOPY:

The risks of Colonoscopy are rare, but may be serious and life threatening. These risks include perforation of the colon by the Colonoscope, which usually requires surgical repair. It is possible that a Colostomy may need to be performed during the repair of a perforation. Additional risks include bleeding, which is most likely to occur after removal of a polyp. Bleeding is usually self-limited, but may be serious and can possibly require transfusions and/or surgery to control. Infections, leakage of air from the bowel into the abdominal cavity are also possible complications. Additional risks associated with any invasive procedure, but not specifically associated with Colonoscopy include unanticipated bleeding, development of blood clots, tissue damage, respiratory problems, infections, and cardiovascular or pulmonary complications. **I understand that do not resuscitate directives will not be honored at this facility.**

SEDATION:

During Colonoscopy I will receive intravenous medicine for sedation. This technique may use several different medications alone or in combination, which result in the induction of a sleep like state, during which memory is often impaired. The degree of sedation varies from person to person and it is conceivable that some pain may be felt during the procedure or some discomfort remembered after the procedure. My physician is limited in the amount of medicine that can be administered by safety factors and changes in my vital signs. Complications from sedation include: Inadequate Respiration, which may require respiratory assistance or reversal of the sedative, low blood pressure, erratic or slow pulse rate, all of which may require administration of additional medications.

4. ACKNOWLEDGEMENT

I understand the need for Colonoscopy. I understand the potential benefit of the procedure and the potential risks associated with it.

5. CONSENT

I give my consent to have the procedure performed by Dr. _____.

_____ _____

Patient/Legal Representative Witness

_____MD _____

Physician Signature Dat

Magnesium Citrate Colonoscopy Instructions

Your Colonoscopy has been schedules for, day and date_____time___
Please arrive ½ hour prior to your appointment

Purchase 3 bottles of Magnesium Citrate (except red) at any pharmacy. You do not need a prescription. Magnesium Citrate is a safe and effective method to cleanse the colon for most patients. If you have any kidney problems, this prep should not be used for you. An excellent prep means excellent visualization of the colon and a more comfortable exam.

Please read the instructions below carefully and discuss any questions that you have prior to your exam. We may have to reschedule your colonoscopy if your prep is not adequate.

1) **ONE WEEK PRIOR:** After checking with your physician do not take any iron pills or medicine that can cause bleeding (ie: Aspirin,Percodan,Alka-Seltzer). Also stop any anti-inflammatory type drugs (ie: Ibuprofen,Motrin,Naproxen, Indocin,Diclofenac, Voltaren—unless approved by your gastroenterologist) ***if you take coumadin (warfarin), Plavix, Plentyl, Aggrenox, Trental…you should discontinue taking it prior to your procedure unless specified by your PCP.*
2) **FIVE DAYS PRIOR:** Restricted residue diet—no nuts, seeds, popcorn, corn.
3) **THE DAY BEFORE** you are to start a CLEAR LIQUID DIET, no solid food! This should start at breakfast. Samples of acceptable foods include:
   - Black tea/coffee (no milk or cream)
   - Clear broth/bouillon
   - Italian ice or popsicles
   - Gatorade, apple or cranberry juice, any clear or carbonated beverage (Soft drinks, Gatorade, flavored water, etc)
   - Jello

   No solid food or juice with pulp!! No Milk products!! Food dyes (specifically RED) should be avoided

   Beginning at 4:00 pm drink one 10oz bottle of Magnesium Citrate. At 6:00 pm drink another 10 oz bottle of Magnesium Citrate. To prevent dehydration, drink plenty of clear liquids all evening (at least 64 oz). Stay close to toilet facilities at this time! If you develop irritation from frequent bowel movements, use a soothing cream such as Vaseline, A+D ointment, or balmex.
4) **DAY OF EXAM:** 3-4 hours prior to your exam, drink another bottle of Magnesium Citrate. Please continue to drink fluids up to 3 hours prior to exam. Any prescribed meds may be taken with a sip of water. Please bring with you any paperwork that you've filled out for this appointment.
   If you are an insulin dependant diabetic, please check with your physician regarding dosages!!!!**
5) **<u>You will be given medication that will sedate you during the procedure. Because of this, you will not be allowed to drive yourself home or take public transportation. You must have somebody accompany you home following the procedure!!!</u>**

Colonoscopy

Frequently Asked Questions and Answers

Q: What is a Colonoscopy?

A: A colonoscopy is an examination of the colon using a flexible scope. This technique has the ability to diagnose most of the common diseases of the colon and removal of small growths or polyps. A colonoscopy is well-tolerated and rarely causes much pain. Air is used to inflate your colon so that the physician can visualize the inner walls, you sense this as a gas cramp and this is why sedation is used.

Q: What type of Sedation is used?

A: A Moderate (Conscious) Sedation is used. Moderate sedation is the use of medications to depress the level of consciousness in a patient while allowing the patient to breathe independently and respond appropriately to verbal commands and/or gently stimulation. Most patients sleep through the exam and wake just as the exam is finishing.

Q: What are Polyps?

A: Polyps are abnormal growths in the colon lining that are usually benign. They vary in size from a tiny dot (the size of a freckle) to several inches. There are 2 main types of polyps: adenomas (pre-cancerous) and hyperplastic (benign, non-cancerous). Your doctor can't always differentiate between the 2, benign vs precancerous, by its outer appearance, so he/she sends the removed polyps to a pathologist for analysis. Because cancer begins as a polyp, removing them is an important means of preventing colon cancer.

Q: What happens after a Colonoscopy?

A: The physician will speak with you after the exam and review preliminary results. Biopsies may take up to one week to result from pathology. Sedation will be used during the procedure so someone must drive you home and stay with you. Even if you feel alert after the procedure, your judgment and reflexes will be impaired for the rest of the day. You might have some cramping or bloating because of the air introduced into the colon during the exam. This should disappear quickly when you pass gas. You should be able to resume a normal diet after the exam!!!

WEYMOUTH ENDOSCOPY, LLC.

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INSURANCE WAIVER OF LIABILITY

Without a referral, your insurance may not pay for services rendered. If your insurance determines that a particular service is not covered without a referral, your insurance may deny payment for that service.

As your physician, I believe this service is medically necessary, but it may not be payable under your insurance policy. In this specific circumstance, your insurance may deny payment for this service.

• •

I have been informed by my physician's office that I am responsible for payment of this service should my insurance company deny payment.

_______________________________ ______________
Signature Date