SOUTH SUBURBAN GASTROENTEROLOGY, PC
WEYMOUTH ENDOSCOPY, LLC

BERNARD F. SMITH, M.D. ~ JOHN P. VERMEULEN, M.D.
FERNANDO J. MARTINEZ, M.D. ~ CLAYLAND F. COX, M.D.
GREGORY M. BOLDUC, M.D. ~ BRADFORD C SAMPSON, MD

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 GASTROSCOPY

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

_____

1. CONDITION

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

2. PROCEDURE

DESCRIPTION OF GASTROSCOPY:

Gastroscopy is an examination of the Esophagus, Stomach and Duodenum, using a flexible scope, which will be inserted through the mouth and advanced under visual guidance throughout the upper gastrointestinal tract. During Gastroscopy, an image of the inside lining of the Esophagus, Stomach and Duodenum is portrayed on a video monitor and reviewed by my physician. This technique allows the physician a detailed examination of the lining of the upper gastrointestinal tract where pathology is most likely to occur. This technique has the ability to diagnose most of the common diseases affecting the upper gastrointestinal tract and to exclude those diagnoses, which are of the greatest concern.

ADDITIONAL PROCEDURES:

Additional procedures are commonly performed during Gastroscopy, which include biopsies of the surface of the Esophagus, Stomach or Duodenum, removal of polyps and cautery of abnormal blood vessels. In additional special circumstances, injection of medicines to retard bleeding from abnormal blood vessels may be required, dilation of strictures and bonding of varices. These procedures are performed routinely in Gastroscopy if the appropriate pathology is identified during that examination. Any tissue removed during Gastroscopy will be sent to a pathology department where it will be reviewed by a pathologist.

3. RISKS AND BENEFITS

RISKS OF GASTROSCOPY:

The risks of Gastroscopy are rare, but may be serious and life threatening. These risks include perforation of the Intestinal Tract, which usually requires surgical repair, bleeding, which may come from biopsy or removal of tissue. Bleeding is usually self- limited, but may be serious and can require transfusions and/or surgery to control. Infections and leakage of air from the intestinal tract into the abdominal cavity or chest cavity may occur. Additional risks associated with any invasive procedure include post procedure pain, tissue damage, bleeding, blood clots, respiratory problems and infections. Additional procedures performed during Gastroscopy, such as Esophageal Dilation may have their own complications including perforation of the Esophagus or Stomach. I understand that do not resuscitate directives will not be honored at this facility.

SEDATION:

During Gastroscopy I will receive intravenous medication for sedation. This technique uses several medications alone or in combination, which results in the induction of a sleep-like state, during which memory is often impaired. The degree of sedation varies and it is conceivable that some degree of pain or some discomfort may be felt during the examination. My physician is limited in the amount of medicine that can be administered by safety factors and changes in my vital signs. Complications for sedation include: inadequate respiration, which may require assistance with breathing and/or reversal of the sedation, low blood pressure, slow or erratic pulse rate, which may require additional medications to be administered.

4. ACKNOWLEDGEMENT

I understand the need for Gastroscopy. I understand the potential benefits of the procedure and the potential risks associated with it. I understand that do not resuscitate directives will not be honored at Weymouth Endoscopy.

5. CONSENT

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

_____ _____

Patient/Legal Representative Witness

_____MD _____

Physician Signature Date

WEYMOUTH ENDOSCOPY, LLC

1085 Main St ~ South Weymouth, MA 02190
TEL: 781-331-2922 FAX: 781-335-5702

INSTRUCTIONS FOR GASTROSCOPY

NAME: _____

APPOINTMENT: _____ TIME: _____

ARRIVE AT: _____PLEASE BRING INSURANCE CARDS WITH YOU
PLEASE OBTAIN A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN IF NEEDED

PREPARATION:

****WEEK PRIOR**DO NOT TAKE ASPIRIN, ASPIRIN LIKE PRODUCTS OR IRON FOR ONE WEEK** prior to exam. TYLENOL is acceptable. Diabetics and those taking Coumadin should get instructions from the physician before leaving the office.

**** NO FOOD OR DRINK FROM MIDNIGHT THE NIGHT BEFORE YOUR PROCEDURE****
Do not eat any breakfast. You may take your prescribed medications with a small amount of water.

** Bring a list of your current medications with you to endoscopy**

** YOU MAY NOT DRIVE HOME as you will receive intravenous sedation for your exam. Make arrangements for someone to accompany you home.**

The procedure takes 30 minutes; you will be at the Endoscopy Center approximately 2 hours.
.

SOUTH SUBURBAN GASTROENTEROLOGY, PC

WEYMOUTH ENDOSCOPY, LLC.

.

1085MAIN STREET ~ SOUTH WEYMOUTH, MA 02190
TEL 781-331-2922 FAX 781-335-5702

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