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

PATIENT HISTORY FORM REVIEW OF SYSTEMS

Name: _____ Date of Birth: _____

Constitutional			Gastrointestinal		
Recent Weight Change	___YES	___NO	Poor Appetite	___YES	___NO
Fever	___YES	___NO	Difficulty in Swallowing	___YES	___NO
Fatigue	___YES	___NO	Heartburn	___YES	___NO
			Nausea	___YES	___NO
			Vomiting	___YES	___NO
Eyes			Bloating	___YES	___NO
Blurred Vision	___YES	___NO	Belching	___YES	___NO
Glaucoma	___YES	___NO	Regurgitation	___YES	___NO
			Constipation	___YES	___NO
Ears/Nose/Mouth/Throat			Diarrhea	___YES	___NO
Hearing Loss	___YES	___NO	Abdominal Pain	___YES	___NO
Ringing in Ears	___YES	___NO	Recent Change in Bowel Habits	___YES	___NO
Mouth Sores	___YES	___NO	Rectal Bleeding	___YES	___NO
			Black, Tarry Stools	___YES	___NO
Cardiovascular					
Chest Pain	___YES	___NO	Neurological		
Shortness of Breath	___YES	___NO	Headaches	___YES	___NO
Swelling of Ankles	___YES	___NO	Seizures	___YES	___NO
			Numbness	___YES	___NO
Respiratory			Strokes	___YES	___NO
Chronic Cough	___YES	___NO			
Spitting up Blood	___YES	___NO	Psychiatric		
Wheezing	___YES	___NO	Memory Loss or Confusion	___YES	___NO
			Depression	___YES	___NO
Genitourinary					
Burning with Urination	___YES	___NO	Endocrine		
Blood in Urine	___YES	___NO	Heat Intolerance	___YES	___NO
			Cold Intolerance	___YES	___NO
			Excessive Thirst	___YES	___NO
Musculoskeletal			Excessive Urination	___YES	___NO
Joint Pain	___YES	___NO			
Swelling	___YES	___NO	Hematological		
Back Pain	___YES	___NO	Bleeding Tendency	___YES	___NO
Muscle Pain	___YES	___NO	Bruising Tendency	___YES	___NO
			Anemia	___YES	___NO
Skin			Past Transfusion	___YES	___NO
Rash	___YES	___NO	Are you Pregnant?	___YES	___NO
Itching	___YES	___NO			

Do you take any blood thinners? No ☐ Yes ☐ What Medication _____

Medication Allergies: _____

List of Medications and Doses:

_____

_____

_____

_____

Comments/Concerns:

_____

PATIENT HISTORY FORM

Name _____ Date of Birth_____

Race: White Asian African American Native Hawaiian/Other Pacific Islander American Indian/Alaskian Native

Ethnicity: Hispanic/Latino Non Hispanic/Latino Language: _____ Height: _____ Weight: ____

Primary Care Physician: _____Pharmacy: _____ Location: _____

Reason for today's visit: _____

List all prior surgeries and date: _____

_____

Circle Present and Past Medical History:

Anemia Angina Anxiety Arrhythmia Arthritis Asthma Blood Clot in Leg or Lung Bronchitis Cancer Congestive Heart Failure Constipation Crohn's Disease Depression Diabetes Elevated Cholesterol Emphysema Heart Attack Heart Murmur Hepatitis Hiatal Hernia Hypertension Irritable Bowel Syndrome Peptic Ulcer Reflux Rheumatic Fever Seizure Sleep Apnea Stroke Thyroid Disease Tuberculosis Ulcerative Colitis

Other:_____

Have you ever had a colonoscopy before?
☐ No ☐ Yes
If so, when and where? _____

Have you ever had any problems with anesthesia or sedation? ☐ No ☐ Yes
If yes, what happened? _____

Have you ever smoked? ☐ No ☐ Yes
If currently smoking, how many packs per day? _____
If not currently smoking, quit date: _____
Do you drink alcohol? ☐None ☐Occasional ☐Daily
Recreational drug use? ☐ No ☐ Yes
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed
Do you work? ☐ No ☐ Yes Type of Work: _____

Any family history of liver disease, celiac disease, Crohn's, ulcerative colitis, other cancer? _____
Family History Colon Polyps: ☐ No ☐ Yes Whom: _____
Family History Colon Cancer: ☐ No ☐ Yes Whom: _____
Family History of Other Significant Disease(s):_____

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

Reviewed By_____ Date: _____

WEYMOUTH ENDOSCOPY, LLC
PATIENT MEDICATION HISTORY FORM

Name: _____ Date of Birth:_____

Date of Exam: _____

**Please mail back with packet*

Allergies / Sensitivities 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** ☐ _____

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

	N/A	**Yes**	**Number of Days**
Hold Aspirin	☐	☐	_____
Hold Ibuprofen, Aleve, Excedrin	☐	☐	_____
Hold Blood Thinners	☐	☐	_____

☐ Due to your endoscopic intervention, please refrain from Aspirin and NSAID products for _____ days

MD signature: _____ Date: _____

Nursing Documentation: Today you had the following procedure:
Colonoscopy ____ Gastroscopy____ Flexible Sigmoidoscopy____

You were given the following medications: Propofol __ Fentanyl __ Versed __ Zofran __ Other _____

Endoclip was used today Yes ☐ - If yes and you require an MRI in the next month, please notify the Radiologist.

Nurse Signature: _____ 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 Date

MAGNESIUM CITRATE PREPARATION: 3 BOTTLES

Purchase 3 bottles of Magnesium Citrate (not red) from any pharmacy. No prescription needed.

One week prior to procedure:

1- Please check with your PCP and your gastroenterologist if you take any blood thinners such as Warfarin/Coumadin, Eliquis, Xarelto, Brilinta, Pradaxa, Plavix, or Aggrenox.
2- Aspirin should not be held.
3- You may continue any NSAID's such as Ibuprofen, Motrin, Aleve, Naproxen, Diclofenac, or Indocin.
4- Please hold iron pills after checking with your PCP.
5- If you are a diabetic, check with your PCP regarding diabetic medication dosing for this procedure.

Five days prior to procedure:

1- Do not consume any nuts, seeds, popcorn, or corn.
2- Hold any fiber supplements.

Day before the procedure:

1- No solid foods are permitted.
2- Clear liquids are to be consumed all day. Please drink plenty of clear liquids throughout the day and evening. This helps to achieve a more effective preparation and prevents dehydration.
3- Examples of clear liquids include: Crystal Light, Gatorade, Powerade, soda, apple juice, seltzer, flavored water, black tea/coffee, Italian ice, popsicles, Jell-O and broth. No milk or cream. Avoid red color in popsicles, Italian ice, Jell-O, Gatorade, etc.
4- At 4:00 o'clock, drink one bottle of Magnesium Citrate.
5- At 6:00 o'clock, drink the second bottle of Magnesium Citrate.

Day of exam:

1- 4 hours prior to your exam time, drink the third bottle of Magnesium Citrate.
2- You may drink clear fluids up to 3 hours prior to your exam time.
3- No solid foods are permitted.
4- You may take any prescription medications.

If you have kidney disease, please call us to confirm this preparation

You must have a ride home from a family member or friend as public transportation is not allowed. You are not able to drive for the remainder of the day.

South Suburban Gastroenterology, PC
Weymouth Endoscopy, LLC
1085 Main Street, South Weymouth
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