

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

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  
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 Tendency              \_\_\_ YES \_\_\_ NO  
Anemia                          \_\_\_ YES \_\_\_ NO  
Past Transfusion                \_\_\_ YES \_\_\_ NO  
Are you Pregnant?                \_\_\_ 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/Alaskan 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 smoked?  No  Yes  
 If currently smoking, how many packs per day? \_\_\_\_\_  
 If not currently smoking, quit date: \_\_\_\_\_

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

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:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hold Ibuprofen, Aleve, Excedrin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hold Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 GASTROSCOPY

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

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### 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 Dilatation 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

\_\_\_\_\_  
Physician Signature MD

\_\_\_\_\_  
Date

South Suburban Gastroenterology, PC  
Weymouth Endoscopy, LLC  
1085 Main Street, South Weymouth  
TEL: 781-331-2922 FAX: 781-335-5702

### **Instructions for Gastroscopy**

Name: \_\_\_\_\_

Your procedure has been scheduled on: \_\_\_\_\_ at \_\_\_\_\_.

Please arrive at: \_\_\_\_\_

Please bring your insurance cards and a photo ID with you on the day of the procedure.  
Please obtain a referral from your primary care physician if needed.

#### **Preparation:**

##### **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- If you are a diabetic, check with your PCP regarding diabetic medication dosing for this procedure.

##### **Day before the procedure:**

- 1- Do not eat or drink after midnight the night before your exam.

##### **Day of exam:**

- 1- Continue not to eat or drink until after the procedure.
- 2- You may take your prescribed medications with a small sip of water.
- 3- Please bring in your health history form and medication list if you have not mailed them in yet.

Please call if you have questions or concerns about your procedure.

**\*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.\***

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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