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
Past transfusion ___YES ___NO
Anemia ___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/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

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
Resume Aspirin	☐	☐	_____
Resume Ibuprofen, Aleve, Excedrin	☐	☐	_____
Resume 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: Versed____ Fentanyl_____ Zofran_____ Propofol_____ Lidocaine____ Glycopyrrolate____ 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:

_____

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

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