WESTSIDE Gastroenterology ASSOCIATES

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# ESTABLISHED PATIENT INTAKE FORM

**FORM MUST BE COMPLETED IN FULL**

**Today's Date:**_____

**Name:**_____ **DOB:**_____ **Age:**_____

**Referred by:** _____ **Phone:**_____

**Primary Care Physician:**_____ **Phone:** _____

**Have you had a screening colonoscopy?** ☐ Yes ☐ No **When**: _____ **Where**:_____

**For use by WESTSIDE GASTROENTEROLOGY ASSOCIATES:**

**Height**:___' ___" **Weight**:_____ lbs. **Vital Signs:**_____ **Temp:**_____ **BP:**_____ **HR:**_____ **RR:**_____

## *ITEMS TO REVIEW & UPDATE*

- **ALLERGIES**
- **MEDICATIONS**

***Patient should bring list to each office visit; Review item or list with patient; Include OTC meds; Include supplements*

- **SURGICAL HX:**
- **HABITS:**

***i.e, Tobacco*

- **SOCIAL HX**
- **FAMILY HX**

***Ask for changes in immediate family only*

## *REVIEW OF SYMPTOMS*

**RISK FACTORS**:
*Recent hospitalization or ER visit:*
*Recent use of antibiotics:*

**GENERAL:**
*Loss of appetite: Weight loss:*
*Fever: Chills: Malaise:*
*Recent illness:*

**DERMATOLOGIC:**
*Rash: Itching:*

**RESPIRATORY:**
*Cough: Wheezing:*
*Shortness of breath:*

**CARDIOVASCULAR:**
*Chest pain: Palpitations:*
*Ankle swelling:*

**GASTROINTESTINAL:**
*Difficulty swallowing: Nausea:*
*Vomiting: Abdominal pain:*
*Diarrhea: Constipation:*
*Rectal bleeding: Black stool:*

**GENITOURINARY:**
*Difficulty urinating:*
*Frequent urination:*

**NEUROLOGICAL:**
*Dizziness: Weakness of arm/leg:*

**ENDOCRINE/METABOLIC:**
*Excessive thirst:*

**MENTAL STATUS/PSYCHIATRIC**
*Anxiety: Depression:*
*Difficulty sleeping:*

**Describe the reason for your visit today:**
_____
_____
_____
_____
_____

**Location:**

**Onset/Duration:**

**Type/Quality:**

**Exacerbate/Relieving:**

**Associated Symptoms:**

**Previous Episodes:**

**Visits to ER or Dr's visits:**

**Previous Workup:**