Kumar Desai, MD – Gastroenterology/Hepatology & Advanced Therapeutic Endoscopy

PATIENT REGISTRATION

Today's date:				**Primary Care Physician**:		
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:					Home phone no.: ( )	
City:	State:		ZIP Code:		Cell phone no.:	
Occupation:	Email Address:				Would you like email reminders and web portal access? (circle one) Yes No	
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.			❑ Insurance Plan	❑ Hospital
❑ Family/Friend	❑ Advertisement	❑ Internet	❑ Other			
Other family members seen here:						
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )	
Is this person a patient here? ❑ Yes ❑ No						
Occupation:	Employer:	Employer address:			Employer phone no.: ( )	
Is this patient covered by insurance? ❑ Yes ❑ No		Insurance Carrier:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:		Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of local friend or relative in case of emergency:	Relationship to patient:		Home phone no.: ( )		Cell phone no.: ( )	

The above information is true to the best of my knowledge.I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance and authorize Kumar Desai, MD or insurance company to release any information required to process claims.

Authorizations:

1. Authorization for Treatment: I authorize any medical treatment, anesthetics or surgical procedures as the attending physician deems necessary.
2. Authorization to Release: I herby authorize the clinic and it's attending physicians to release any information acquired in the course of my examination.
3. Statement of Financial Responsibility: I understand that I am responsible for payment of charges incurred in the course of treatment within 90 days of initial statement and lack of payment can result in termination of physician-patient relationship.
4. I have received, read and understand Kumar Desai, MD's Notice of Privacy Practice.

Patient/Guardian signature *Date*

HISTORY OF PRESENT ILLNESS

Why are you seeing us today?	
Severity and Location (1-10, where is pain worse)	
Duration (How long have you had this Problem)	
Modifying Factors (What makes it better or worse?)	

MEDICATIONS/HERBALS

Please Circle Any Gastrointestinal Medications you have taken over the past month:

Aspirin containing medications: Excedrin, Aggrenox, Aspirin, Alka-Seltzer
Arthritis medications: Naprosyn, Motrin, Ibuprofen, Advil, Aleve If circled >>>>How many per day? _____
Nerve pills: Xanax, Valium, Prozac, Zoloft, Paxil, Wellbutrin, Abilify
Blood thinners: Plavix, Warfarin, Pradaxa, Brilinta, Eliquis, Aspirin, Fish oil, Ginkgo biloba
Herbal Products _____

Other Medications: (Include over the counter and herbal products)
Name Dose /Frequency Condition Being Treated

1. _____ **6.** _____
2. _____ **7.** _____
3. _____ **8.** _____
4. _____ **9.** _____
5. _____ **10.** _____

ALLERGIES

Please list allergies to latex, iodine, foods, and medicines

MEDICAL HISTORY

Please check boxes below:

COPD	☐ No	☐ Yes	**Stress/Anxiety**	☐ No	☐ Yes
Asthma	☐ No	☐ Yes	**Stroke**	☐ No	☐ Yes
Cancer	☐ No	☐ Yes	**Hepatitis/Liver Disease**	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	**HIV/AIDS**	☐ No	☐ Yes
Heart Failure/Heart Attack	☐ No	☐ Yes	**Obstructive Sleep Apnea**	☐ No	☐ Yes
Hypertension	☐ No	☐ Yes	**Lupus/Rheumatologic dz**	☐ No	☐ Yes

SURGICAL HISTORY (please list surgeries and dates below):

SOCIAL HISTORY

Please Circle below:

Alcohol Use:	Never	Number per week? _____		How many daily? _____	
Tobacco Use:	Never	Previously, but quit	Currently	How many packs per day?	How many years?
Caffeine Use:	Never	Number per day? _____			
Drug Use:	Never	Rarely	Daily	Drugs Used:	

FAMILY HISTORY

Please list any gastrointestinal problems in your family (parents, siblings, grandparents). Examples include: stomach/colon/liver problems, polyps, Crohn's, Ulcerative Colitis, cancers of breast/ovarian/colon/stomach/liver, ulcers

_____
_____
_____
_____

GI PROCEDURE HISTORY

Have you ever had any of the following studies? (please circle):

		Where	Results	Date
Colonoscopy	Yes No	_____	_____	_____
CT of abdomen	Yes No	_____	_____	_____
Endoscopy (stomach)	Yes No	_____	_____	_____
Flexible Sigmoidoscopy	Yes No	_____	_____	_____
ERCP	Yes No	_____	_____	_____

PHARMACY

OTHER PHYSICIANS SEEN

In order to assist in your care please list the physicians you currently see:

REVIEW OF SYSTEMS

Gastrointestinal		
Abdominal Pain	☐ No	☐ Yes
Acid Reflux/GERD	☐ No	☐ Yes
Excessive Belching	☐ No	☐ Yes
Food Sticking	☐ No	☐ Yes
Heartburn	☐ No	☐ Yes
Indigestion	☐ No	☐ Yes
Loss of Weight	☐ No	☐ Yes
Loss of Appetitie	☐ No	☐ Yes
Nausea/Vomiting	☐ No	☐ Yes
Painful Swallowing	☐ No	☐ Yes
Black Stool	☐ No	☐ Yes
Vomiting Blood	☐ No	☐ Yes
Blood in Stool/Rectal Bleeding	☐ No	☐ Yes
Bowel Movement Urgency	☐ No	☐ Yes
Change in Bowel Habits	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Fecal Soiling	☐ No	☐ Yes
Gas/Bloating	☐ No	☐ Yes
Hemorrhoids	☐ No	☐ Yes
Rectal Pain	☐ No	☐ Yes
Cardiovascular		
Chest Pain	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes
Swelling Feet or Ankles	☐ No	☐ Yes
Constitutional Symptoms		
Fever	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Headaches	☐ No	☐ Yes
Recent Weight Changes	☐ No	☐ Yes
Eyes		
Blurred or Double Vision	☐ No	☐ Yes
Eye Disease or Injury	☐ No	☐ Yes
Glasses/Contacts	☐ No	☐ Yes
Ears/Nose/Mouth/Throat		
Bad Breath/Taste	☐ No	☐ Yes
Chronic Sinusitis/Rhinitis	☐ No	☐ Yes
Earaches	☐ No	☐ Yes
Hearing Loss/Ringing	☐ No	☐ Yes
Mouth Sores	☐ No	☐ Yes
Nose Bleeds	☐ No	☐ Yes
Sore Throat/Voice Change	☐ No	☐ Yes
Dermatologic		
Itching	☐ No	☐ Yes
Rash	☐ No	☐ Yes
History of Skin Cancer	☐ No	☐ Yes

Respiratory		
Asthma/Wheezing	☐ No	☐ Yes
Chronic Cough	☐ No	☐ Yes
Shortness of Breath	☐ No	☐ Yes
Coughing Up Blood	☐ No	☐ Yes
Endocrine		
Cold/Heat Intolerance	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Dry Skin	☐ No	☐ Yes
Excessive Thirst	☐ No	☐ Yes
Hematologic		
Anemia	☐ No	☐ Yes
Easy Bleeding/Bruising	☐ No	☐ Yes
Enlarged Glands	☐ No	☐ Yes
Past Blood Transfusion	☐ No	☐ Yes
Slow to heal after cuts	☐ No	☐ Yes
Musculoskeletal		
Back Pain	☐ No	☐ Yes
Joint Stiffness/Swelling	☐ No	☐ Yes
Cold Extremities	☐ No	☐ Yes
Difficulty Walking	☐ No	☐ Yes
Muscle Pain/Cramping	☐ No	☐ Yes
Weakness of Muscles/Joints	☐ No	☐ Yes
Neurological		
Dizziness	☐ No	☐ Yes
Frequent Headaches	☐ No	☐ Yes
Head Injury	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Seizures or Convulsions	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Tingling or Numbness	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Psychiatric	☐ No	☐ Yes
Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Anorexia/Bulemia	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes
Memory Loss/Confusion	☐ No	☐ Yes
Genitourinary	☐ No	☐ Yes
Blood in Urine	☐ No	☐ Yes
Burning/Painful Urination	☐ No	☐ Yes
Frequent Urination	☐ No	☐ Yes
Kidney Stones	☐ No	☐ Yes
Urinary Incontinence	☐ No	☐ Yes
Male – Testicle Pain	☐ No	☐ Yes
Sexual Difficulty	☐ No	☐ Yes