Bucks County Gastroenterology Associates, P.C.

New Patient Medical History Intake Form

Patient Information -

Date: _____

Patient Name: _____ Date of Birth: _____ Male ☐ Female ☐

REASON FOR VISIT _____

Marital Status: M__ D__ S__ W__

Occupation: _____ Employer: _____

Spouse Name: _____

Parent/Legal Guardian Name: _____

State/Country of Birth: _____ Special Communication Needs: _____

Language: _____ Race: _____ Decline ☐ Ethnicity: _____ Decline ☐

Patient Contact Information –

Address: _____ City: _____

State: _____ Zip: _____ County: _____ Preferred Phone Number: _____

Is this phone number? ☐ Cell ☐ Home ☐ Work

May we leave **detailed** messages at this phone? ☐ NO ☐ YES

Secondary Phone: _____ Email: _____

Emergency Contact Information -

Name	Relationship	Phone Number	Address

I hereby authorize Bucks county Gastroenterology to discuss and or release my protected health information to: Myself Only ☐

Name	Relationship	Phone

Advanced Care Directive - Do you have an Advance Directive or Living Will? ☐ NO ☐ YES

Have you designated a Durable Power of Attorney? ☐ NO ☐ YES If yes, please enter information below:

Name	Relationship	Phone Number	Date

Specialist Contact Information - (Please provide first and last names)

	Physician Name	Office Name	Location
PCP:			
Cardiologist:			
Gynecologist:			
Other:			

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Adult Vaccination/Immunization History - (If available please attach childhood immunizations separately)

	Date		Date		Date
Hepatitis A		Zoster		Flu	
Hepatitis B		Shingrix		Pneumococcal	

Health History - Have you ever been diagnosed with any of the following:

☐ Stomach Ulcer	☐ Thyroid Disorder	☐ Heart Disease / CAD	☐ Depression	Other Health Conditions
☐ Reflux Disease	☐ Diabetes	☐ Heart Attack	☐ Anxiety	
☐ Gall Bladder	☐ Arthritis	☐ Heart Murmur	☐ Eating Disorder	
☐ Pancreatitis	☐ Kidney Disease	☐ Heart Failure	☐ Drug Addiction	
☐ Colitis	☐ Seizures / Epilepsy	☐ High Cholesterol	☐ Alcoholism	
☐ Diverticulitis	☐ Parkinson's Disease	☐ Asthma	☐ Osteoporosis	
☐ Irritable Bowel	☐ High Blood Pressure	☐ Seasonal Allergies	☐ Tuberculosis	
☐ Hepatitis	☐ Stroke	☐ Sleep Apnea	☐ Anemia	
☐ Liver Disease	☐ Multiple Sclerosis	☐ Emphysema / COPD	☐ Bleeding Disorder	
☐ Polyps	☐ Migraines/Headache	☐ Pulmonary Clotting	☐ Blood Clot	
☐ IBD Type: _____	☐ Cancer Type: _____	☐ Peripheral Vascular Disease	☐ Autoimmune Disease Type: _____	

Family history - Adopted ☐

Relation	Current Age,if living	Age at Death	Polyps	IBD	Liver Disease	Celiac	Pancr-eatitis	Gallbladder Disease	Cancer	Type	Other
Father			☐	☐	☐	☐	☐	☐	☐		
Mother			☐	☐	☐	☐	☐	☐	☐		
Maternal Grandmother			☐	☐	☐	☐	☐	☐	☐		
Maternal Grandfather			☐	☐	☐	☐	☐	☐	☐		
Paternal Grandmother			☐	☐	☐	☐	☐	☐	☐		
Paternal Grandfather			☐	☐	☐	☐	☐	☐	☐		
Sibling			☐	☐	☐	☐	☐	☐	☐		
Sibling			☐	☐	☐	☐	☐	☐	☐		
Other relative			☐	☐	☐	☐	☐	☐	☐		

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Surgical History - None ☐

Procedure	Date

Current Medications with Dosages - None ☐

Social history - Details Attached ☐

Tobacco Use: ☐ YES ☐ NO ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew Amount per day: _____ Number of years tobacco use: _____ Former tobacco user: ☐ YES ☐ NO Last tobacco use: _____ ☐ QUIT Years quit: _____	Alcohol Consumption: ☐ YES ☐ NO Number of drinks per week: _____ Preferred drink (ie: beer, wine, spirits): _____ ☐ QUIT Years quit: _____	Recreational Drug Use: ☐ YES ☐ NO Type: _____ Amount per week: _____ Last used: _____ ☐ QUIT Years quit: _____
Caffeine: ☐ YES ☐ NO # of caffeine drinks per day: _____	Do you use e-cigarettes, vape or other? ☐ YES ☐ NO	

Allergies - No Known Drug Allergies ☐ Latex: Yes ☐ No ☐
