Dartmouth-Hitchcock
MANCHESTER

Place patient label here

Gastroenterology & Hepatology

New Patient Intake Form

Today's Date _____

Name _____ Date of Birth _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other _____

Gender ☐ Male ☐ Female

EMPLOYMENT

Employer _____

PERSONAL HISTORY

Describe the reason(s) for your visit _____

_____

Referred to Gastroenterology by _____ Primary Care Physician _____

Other physicians involved in your care _____

Provide details regarding current and/or past use of the following:

Alcohol (beer, wine, liquor)	☐ Yes	☐ No	Weekly Consumption _____
IV or Recreation Drugs	☐ Yes	☐ No	Usage/Frequency _____
Recent colonoscopy/EGD?	☐ Yes	☐ No	Where? _____
Recent Imaging? (CT, XRAY, U/S)	☐ Yes	☐ No	Where? _____
Recent labs?	☐ Yes	☐ No	Where? _____

PATIENT MEDICAL HISTORY (check all that apply)

☐ Cirrhosis	☐ Hepatitis B	☐ Anemia	☐ High Blood Pressure	☐ Scleroderma
☐ Colon Cancer	☐ Hepatitis C (HCV)	☐ Stroke	☐ Colon Polyps	☐ Hiatal Hernia
☐ Anxiety/Depression	☐ HIV/AIDS	☐ Crohn's Disease	☐ Irritable Bowel	☐ Cancer: _____
☐ Irregular Heartbeat	☐ Diverticulitis	☐ Celiac Disease	Syndrome (IBS)	☐ Kidney Disease
☐ Diverticulosis	☐ Liver Disease	☐ Obesity	☐ End Stage Renal	☐ Stomach/Intestinal
☐ Diabetes	☐ Osteoporosis	☐ Pancreatitis	Disease (ESRD)	Ulcers
☐ GERD/reflux	☐ Ulcerative Colitis	☐ Seizures	☐ Heart Disease/Attack	

Other past medical history not listed: _____

_____

PAST SURGICAL HISTORY

_____

_____

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FAMILY HISTORY	Mother	Father	Siblings	Son	Daughter	Grandmother	Grandfather
Barrett's Esophagus	☐	☐	☐	☐	☐	☐	☐
Cancer							
Breast	☐	☐	☐	☐	☐	☐	☐
Colon	☐	☐	☐	☐	☐	☐	☐
Esophagus	☐	☐	☐	☐	☐	☐	☐
Lung	☐	☐	☐	☐	☐	☐	☐
Pancreas	☐	☐	☐	☐	☐	☐	☐
Stomach	☐	☐	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐
Crohn's Disease/Colitis	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Wheat Allergy (Celiac)	☐	☐	☐	☐	☐	☐	☐
Other? _____	☐	☐	☐	☐	☐	☐	☐

SYSTEM REVIEW

Do you have or have you experienced any of the following in the last 6 months?

GASTROINTESTINAL
- ☐ Abdominal Pain/Discomfort
- ☐ Anal/Rectal Pain or Itching
- ☐ Black Stool
- ☐ Bloating/Belching/Gas
- ☐ Change of Bowel Habits
- ☐ Constipation
- ☐ Diarrhea/Loose Stool
- ☐ Difficulty Swallowing
- ☐ Heartburn/reflux
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Mucus in Stool
- ☐ Nausea/Vomiting
- ☐ Pain w/ Bowel Movements
- ☐ Rectal Bleeding

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Heart Racing/Skipping
- ☐ Palpitations

RESPIRATORY
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Wheezing or Asthma

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Joint Pain/Arthritis

GENITOURINARY
- ☐ Are you pregnant?
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Recent Urinary Tract Infection

SKIN / EYES / MOUTH
- ☐ Itching/Dry Skin
- ☐ Jaundice (yellow eyes or skin)
- ☐ Visual Changes
- ☐ Mouth Ulcers/Sores

HEMATOLOGY / LYMPHATIC
- ☐ Bleeding Problems
- ☐ Excessive Bruising
- ☐ History of Anemia

NEUROLOGIC
- ☐ Headache
- ☐ Dizziness/Vertigo
- ☐ Head Trauma/Injury
- ☐ Recent Numbness/Weak

CONSTITUTIONAL
- ☐ Fatigue
- ☐ Loss of Appetite
- ☐ Night Sweats
- ☐ Weight Loss

PSYCHIATRY
- ☐ Anxiety
- ☐ Depression