Hudson Valley Gastroenterology PC

NEW PATIENT PAPERWORK

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YOUR APPOINTMENT DATE:_____ **ARRIVAL TIME:** _____
LOCATION: 26 Pearl St. Kingston, NY **OR** 124 Tinker St. Woodstock, NY

Please complete the enclosed forms and bring them with you on the day of your appointment along with your photo ID & insurance card(s).

HOW DID YOU HEAR ABOUT US?

___ MD Referral
___ Newspaper
___ Phonebook
___ Internet
___ Family/Friend
___ Other (please note)

HVG No Show and Cancellation Policy

I agree that I must arrive at my scheduled appointment on time so that the Practice is able to dedicate the time necessary to provide the best possible care and treatment to me and other patients. I agree that if I have to change or cancel an appointment, I will notify the Practice 48 hours prior to my scheduled office visit and 72 hours prior to any scheduled procedure. All notifications must be by telephone (845-331-8222) and require that you speak to an office staff member. Voice mail messages or messages left with the call center are not acceptable forms of notification. If I fail to cancel or reschedule a scheduled appointment, I will be responsible for paying an administrative fee of $100.00 for office visits and $150.00 for procedures and will not be able to schedule another appointment until the administrative fee is paid. I understand and agree that repeated cancellations or no-shows may result in discharge from the Practice.

At the time of your appointment, you will be asked to electronically acknowledge that you have been provided with a copy of this document in advance, read this document in its entirety or had it read to me, fully understand and agree to its terms, and all of my questions have been answered to my satisfaction.our cancellation policy

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PATIENT INTAKE FORMS

DATE: _____ PATIENT NAME: _____ DOB: _____

Please list all current medications with dosage including over the counter and supplements

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any known allergies or sensitivities including those to metals? Please list reactions.

_____

Please check any that apply:

____ Liraglutide (Victoza, Saxenda)	____ Tirzepatide (Manjaro)	____ Canagliflozin (Invokana)
____ Exenatide (Bydureon Bcise)	____ Dulaglutide (Trulicity)	____ Dapagliflozin (Farxiga)
____ Semaglutide (Ozempic, Wegovy)	____ Semaglutide (Rybelsus)	____ Empagliflozin (Jardiance)
____ Ertugliflozin (Steglatro)	____ Lixisenatide (Adlyxin)	____ Exenatide (Byetta)

Approximate Date of the Last Following:

***Pneumovax** Month/Year _____ ***Breast Cancer Screening** Month/Year _____

***Flu Vaccine** Month/Year _____ ***Pap Smear** Month/Year _____

***Colon Cancer Screening** including: **FIT test** or **Cologuard** (circle one) Month/Year _____ POS or NEG

Do you have any Advanced Directives? *(Example: Do Not Resuscitate or any other instructions)*

_____

Do you have a Health Care Proxy? If yes, please provide name and relationship

_____

Please list any medical problems in the line below

_____

Have you had surgeries or procedures that required anesthesia in the past? What, when and were there any complications to anesthesia?

_____

Please list any assistive devices you may have: *(Example: glasses, cane, walker, hearing aids)*

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FAMILY HISTORY

Please circle all that apply:

FATHER

High Blood Pressure	Sickle Cell Anemia	Other: _____
Heart Disease	Gallstones	Deceased? Cause: _____
Stroke	Colon Polyps	Diabetes
Liver Disease	Colon Cancer	Other Cancer: _____

MOTHER

High Blood Pressure	Sickle Cell Anemia	Other: _____
Heart Disease	Gallstones	Deceased? Cause: _____
Stroke	Colon Polyps	Diabetes
Liver Disease	Colon Cancer	Other Cancer: _____

NUMBER OF SIBLINGS: __

High Blood Pressure	Sickle Cell Anemia	Other: _____
Heart Disease	Gallstones	Deceased? Cause: _____
Stroke	Colon Polyps	Diabetes
Liver Disease	Colon Cancer	Other Cancer:_____

NUMBER OF CHILDREN:

High Blood Pressure	Sickle Cell Anemia	Other: _____
Heart Disease	Gallstones	Deceased? Cause: _____
Stroke	Colon Polyps	Diabetes
Liver Disease	Colon Cancer	Other Cancer: _____

SOCIAL HISTORY

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Legally Separated ___

Domestic Partnership ___

Religious Preferences: _____

Work Status: Full Time ___ Part Time ___ Retired ___ Unemployed ___ Disabled ___

Occupation: _____
Smoking Tobacco: Yes___ No ___ Former ___ If yes, how much per week? _____
Electronic Smoking (Vaping): Yes___ No ___ If yes, how much per week? _____
Recreational/ Illegal Drug Use: Yes___ No ___ If yes, please specify/when:_____
Alcohol Consumption: Yes___ No ___ If yes, how much per week? _____
Do you have any piercings? Yes___ No ___ If yes, where? _____
Do you have any tattoos? Yes___ No ___ If yes, was it done with lead ink? Yes___ No ___
Have you traveled out of the country recently? Yes___ No ___ If yes, where and when?

CONSTITUTION **RESPIRATORY**

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Yes ___ No ___ Decreased Appetite
Yes ___ No ___ Fatigue
Yes ___ No ___ Fever
Yes ___ No ___ Weight Loss
Yes ___ No ___ Weight Gain

EYES
Yes ___ No ___ Cataracts
Yes ___ No ___ Glaucoma
Yes ___ No ___ Corrective Lenses

ENMT
Yes ___ No ___ Hearing Loss
Yes ___ No ___ Seasonal Allergies
Yes ___ No ___ Congestion
Yes ___ No ___ Septal Deviation, Nasal
Yes ___ No ___ Bleeding Gums
Yes ___ No ___ Chronic Cough
Yes ___ No ___ Dental Problems
Yes ___ No ___ Hoarse/Voice Changes
Yes ___ No ___ Hemoptysis - Coughing Up Blood
Yes ___ No ___ Mouth Sores
Yes ___ No ___ Thrush
Yes ___ No ___ TMJ Jaw Discomfort
Yes ___ No ___ Nose Bleeding

HEART
Yes ___ No ___ Angina, Chest Pain
Yes ___ No ___ CVA, Stroke
Yes ___ No ___ Blood Vessel Disease
Yes ___ No ___ Pacemaker
Yes ___ No ___ Arrhythmia
Yes ___ No ___ Automatic Defibrillator
Yes ___ No ___ CHF Congestive Heart Failure
Yes ___ No ___ Congenital Heart Failure
Yes ___ No ___ DVT Vein Thrombosis/Clots
Yes ___ No ___ High Cholesterol
Yes ___ No ___ High Blood Pressure
Yes ___ No ___ MI - Heart Attack

BREAST
Yes ___ No ___ Cancer

Yes ___ No ___ Asthma
Yes ___ No ___ Difficulty Breathing
Yes ___ No ___ COPD - Emphysema
Yes ___ No ___ History of Lung Blood Clots
Yes ___ No ___ Snoring
Yes ___ No ___ Pneumonia
Yes ___ No ___ Sleep Apnea

MUSCULAR
Yes ___ No ___ Osteoporosis
Yes ___ No ___ Arthritis
Yes ___ No ___ Fibromyalgia
Yes ___ No ___ Cancer

SKIN
Yes ___ No ___ Bruising
Yes ___ No ___ Piercings
Yes ___ No ___ Skin Cancer
Yes ___ No ___ Psoriasis
Yes ___ No ___ Reynaud's
Yes ___ No ___ Tattoos with Lead Ink

NEURO
Yes ___ No ___ TIA's Mini Strokes
Yes ___ No ___ Headache
Yes ___ No ___ Memory Loss
Yes ___ No ___ Parkinson's Disease
Yes ___ No ___ Restless Leg Syndrome
Yes ___ No ___ Seizures

PSYCH
Yes ___ No ___ Anxiety
Yes ___ No ___ Eating Disorder
Yes ___ No ___ Depression
Other: _____

ENDOCRINE
Yes ___ No ___ Diabetes 1 OR 2 (Circle)
Yes ___ No ___ Kidney Disease
Yes ___ No ___ Thyroid Disease

HEMA/Lymph
Yes ___ No ___ Bleeding/Clotting Disease
Yes ___ No ___ Blood Transfusion
Yes ___ No ___ Sickle Cell Anemia