BONHEURMD
GASTROENTEROLOGY + ENDOSCOPY

1317 THIRD AVENUE, 7TH FLOOR
NEW YORK, NEW YORK 10021
PHONE: 212.570.2075

Appointment Date_____

MEDICAL QUESTIONNAIRE

Instructions: This medical questionnaire will assist us in understanding your medical status. Please answer all the questions fully, printing or writing legibly. Thank you.

Name:_____ Today's Date:_____

Date of birth:_____ Age:_____ SS#:_____

Home address: Street:_____

City:_____ State:_____ Zip:_____

Phone:_____ Work:_____ Cell:_____

Email:_____

Problem or reason for your visit:_____

Referring physician:_____

Primary care physician ( ) same:_____

Insurance Name:_____ Primary Subscriber? ☐ Yes ☐ No

Contract #:_____ Group #:_____

Secondary Insurance Name:_____

Contract #:_____ Group #:_____

Do you have a living will? ☐ Yes ☐ No

Do you have power of attorney for health care decisions? ☐ Yes ☐ No

SOCIAL HISTORY *(check all that apply)*:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment/School:_____

Stress Issues ☐ Work ☐ Recent Trauma ☐ Illness in Family ☐ Relationship Issues ☐ Family Issues

Comments: _____

Tobacco: ☐ Current ☐ Previously (year quit:_____)

☐ Cigarettes ☐ Chew Tobacco ☐ Cigars ☐ Amount:_____

Alcohol: ☐ Beer ☐ Wine ☐ Liquor ☐ How often:_____

Caffeine: # cups/day:_____

Diet: Are you on a special diet? ☐ Diabetes ☐ Cardiac ☐ Celiac Sprue ☐ Lactose Free ☐ Other

Recreational Drugs: _____

MEDICATIONS - List all medications you presently take including aspirin, vitamins, calcium, laxatives, stool bulking agents, over-the-counter pills, eye drops, etc. Also list medications that you take occasionally. *(Attach additional pages if necessary)*

Medicines	Dosage (if known)	If regular use how often/day	If occasional check here	Reason for use

NON-TRADITIONAL MEDICATIONS / THERAPIES - *(Attach additional pages if necessary)*
Please list current herbs, dietary supplements or alternative therapies.

Medicines	Dosage (if known)	If regular use how often/day	If occasional check here	Reason for use

ALLERGIES - List all allergies to drugs, medicines, bee sting, etc. and give reaction. **Are you allergic to latex? ☐ Yes ☐ No**
Have you been advised to take antibiotics before medical or dental procedures? ☐ Y ☐ N
Are you allergic to Penicillin? ☐ Y ☐ N

Drug/Agent	Reaction	Drug/Agent	Reaction

PREVIOUS GI EVALUATIONS - Give the year, location (hospital or x-ray office) and, if known, result of the following medical studies:

	Year	Location	Result (circle "NL" if normal – "?" if unknown)
Colonoscopy			NL ?
Upper Endoscopy (EGD)			NL ?
Abdominal CAT (CT) Scan			NL ?
Abdominal Sonogram (Ultrasound)			NL ?
Barium Enema			NL ?
Upper GI Series			NL ?

OPERATIONS - List all surgical operations, (especially abdominal, hernia, hemorrhoids, hysterectomy, cardiac, heart valve, pacemaker, artificial joints, cataracts, etc.) Give the year, physician and location.

Operation	Year	Physician	Hospital-City-State

GASTROINTESTINAL HISTORY -

(Please check all that apply to you. Use blank space for additional information.)

UPPER GI:

☐ Frequent mouth ulcers ☐ Stomach ulcers ☐ Weight loss #_____ ☐ Heartburn ☐ Nausea

☐ Swallowing difficulty/food sticking ☐ Belching ☐ Weight gain ☐ Painful swallowing ☐ Black stools

LOWER GI:

☐ Bloating ☐ Excessive rectal gas/flatus ☐ Painful bowel movements ☐ Constipation ☐ Rectal bleeding

☐ Diarrhea ☐ Lower abdominal pain ☐ Colon cancer ☐ Loss of stool/ fecal accidents ☐ Family history of colon cancer: specify_____

DIGESTIVE ORGANS:

LIVER

☐ Yellow eyes (jaundice)
☐ Cirrhosis
☐ Hepatitis: explain_____
☐ Liver transplant
☐ Hepatitis B vaccination
☐ History of blood transfusions

GALL BLADDER

☐ Gallstones
☐ Gallbladder surgery

PANCREAS

☐ Pancreatitis

FAMILY HISTORY - Please provide the following information on your parents, siblings and children.

(circle Male or Female)	Age if Living	Check (✔) if Healthy	Age at Death	Major Illness(es) and/ or cause of death	*(circle Male or Female)*	Age if Living	Check (✔) if Healthy	Age at Death	Major Illness(es) and/ or cause of death
Father					Child M F				
Mother					Child M F				
Sibling M F					Child M F				
Sibling M F					Child M F				
Sibling M F					Child M F				
Sibling M F					Child M F				

GASTROINTESTINAL FAMILY HISTORY* - *(check all that apply)*

	Colon CA	Colon Polyps	Ulcerative Colitis	Crohn's	Irritable Bowel Syndrome	Liver Disease
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐
Brothers #_____	☐	☐	☐	☐	☐	☐
Sisters #_____	☐	☐	☐	☐	☐	☐
Sons #_____	☐	☐	☐	☐	☐	☐
Daughters #_____	☐	☐	☐	☐	☐	☐

*Please add any other important family health information:_____

_____

HISTORY

Do you have a history of any of the following?

Check all that apply.

HEART:

- ☐ Murmur
- ☐ Pacemaker
- ☐ History of heart attack
- ☐ Angina
- ☐ Congestive heart
- ☐ High blood pressure
- ☐ Mitral valve prolapse
- ☐ High cholesterol
- ☐ Leg cramps with walking
- ☐ Palpitations
- ☐ Previously underwent a cardiac catherization
- ☐ Heart transplant
- ☐ Heart valve replacement
  Specify:_____

LUNG:

- ☐ Emphysema or Asthma
- ☐ Lung cancer
- ☐ Chronic cough
- ☐ Difficulty breathing with walking
- ☐ Difficulty breathing lying down
- ☐ Lung transplant

URINARY:

- ☐ Burning with urination
- ☐ Bladder infection/UTI's
- ☐ Kidney disease:_____
- ☐ Dialysis: Hemodialysis ☐ Peritoneal ☐
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Kidney transplant
- ☐ Cancer of the kidney

ENDOCRINE:

- ☐ Thyroid problem or goiter
- ☐ Diabetes
  - ☐ Insulin

REPRODUCTIVE: (female)

- ☐ Are you pregnant or planning a pregnancy
- ☐ Menstrual irregularity
- ☐ Post-menopausal
- ☐ Nipple discharge
- ☐ Cancer of cervix, uterus, ovary, endometrium, breast: _____
- ☐ Pelvic pain
- ☐ Sexually transmitted disease
- ☐ Painful intercourse
- ☐ Vaginal delivery #_____

REPRODUCTIVE: (male)

- ☐ Prostate problem
- ☐ Sexually transmitted disease
- ☐ Hesitancy, dribbling
- ☐ Discharge
- ☐ Impotence
- ☐ Prostate cancer; treatment_____

NERVOUS SYSTEM:

- ☐ Fainting
- ☐ Seizures / Epilepsy
- ☐ Chronic headaches (not migraine)
- ☐ Migraine headaches
- ☐ History of stroke or TIA
- ☐ Insomnia

SKIN:

- ☐ Psoriasis
- ☐ Eczema
- ☐ Acne
- ☐ Skin cancer
  - ☐ Melanoma

EYES:

- ☐ Glasses / Contacts
- ☐ Glaucoma
- ☐ Cataracts

EARS:

- ☐ Difficulty hearing
- ☐ Hearing aid

MUSCULAR/SKELETAL:

- ☐ Arthritis
- ☐ Chronic fatigue
- ☐ Leg cramps at night
- ☐ Degenerative Joint Disease

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REGISTRATION (PLEASE PRINT)

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient