Welcome to our practice. Dr. Blumberg is a Board Certified Colon and Rectal Surgeon.
We ask that you take the time to carefully fill out this patient information form (please print legibly).
We look forward to helping you get well.

A. Demographics:

Your Name: ____ Date of Birth: ____/___/____

Street Address____

City, State, Zip ____

Social Security # ______________ Telephone #'s: Home______________Work ____________Cell _____________

Emergency Contact: Name ________________Relationship ___________ Phone # ___________________

Medical Insurance: _____________ ID# ____________ Group # ____________

Secondary Insurance: _____________ ID# ____________ Group# ___________

Name of Policy Holder:_______________________ Policyholder date of birth:_____________________

B. Consult Requesting Doctor: **Reason:** _____________________

PCP: Name _________________________ Address ________________________________

Tel# ______________________________FAX#____________________________

Gastroenterologist :Name __________________________ Address _________________________

Tel # ___________________ FAX#_____________________________

Other Doctors you would like to receive reports about you (list name, address, telephone and FAX#) :

____

C. Medical Information Release and Assignment of Benefits
I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _________________ Signature _____________________________

I hereby authorize Dr. David Blumberg to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to Dr. David Blumberg (or to a party who accepts assignment). I certify that the information that I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date ___________________________ Signature _________________________
(patient, parent, or guardian)

Continue to next page →

Your Name ____ **Today's Date:** ____________

D.Current Medical Condition

What is your chief complaint? ____

When did these symptoms start? ____

What makes your symptoms better? ____

What makes your symptoms worse? ________________________________ ____________________

Describe any associated symptoms: ____

On a scale of 1-10, list the severity of your symptoms (circle one): 1 2 3 4 5 6 7 8 9 10

E. Past Medical History:
List any surgeries you have had and the dates:

1. ____________________ 3. ____________________ 5. ____________________ 7. ____________________

2. ____________________ 4. ____________________ 6. ____________________ 8. ____________________

Have you ever been hospitalized (list date and reason)?

List all Present and Past Medical Illnesses:

1. ______________________ 2. ______________________ 3. ______________________

4. ______________________ 5. ______________________ 6. ______________________

7. ______________________ 8. ______________________ 9. ______________________

Any Allergies : no ____ yes ____ List medications you are allergic to: ______________________

List Present Medications (include dose and how many times/day taken):

Continue to next page →

Your Name ____ **Today's Date:** _____________

Please check box if you have now or in the past any of the following (or check none):

Constitutional: ☐ weakness ☐ fever ☐ chills ☐ weight loss ☐ weight gain ☐ nausea ☐ **none**

Eyes: ☐ double vision ☐ blurred vision ☐ loss of vision ☐ eye pain ☐ cataracts ☐ glaucoma ☐ **none**

Ears, Nose, Mouth/Throat: ☐ ear pain ☐ hearing loss ☐ vertigo ☐ sinusitis ☐ mouth pain ☐ **none**

Integumentary: ☐ skin rashes ☐ non-healing skin injuries ☐ itchiness ☐ skin cancers ☐ **none**

Neurological: ☐ loss of consciousness/fainting ☐ history of stroke ☐ TIA ☐ seizures ☐headaches ☐ tremors ☐ **none**

Psychiatric: ☐ depressed mood ☐ history of depression ☐ schizophrenia ☐ mania ☐ **none**

Musculoskeletal: ☐ muscle pain ☐ muscle weakness ☐ joint pain ☐ fractures- list site(s) ___________ ☐ **none**

Cardiovascular: ☐ chest pain/pressure ☐ heart disease ☐ heart attack ☐ heart murmur ☐ high blood pressure ☐ rheumatic fever ☐ shortness of breath ☐ arrhythmias ☐ leg pain with walking ☐ leg ulcers ☐ varicose veins ☐ **none**

Respiratory: ☐ shortness of breath ☐ cough ☐ pneumonia ☐ bronchitis ☐ tuberculosis ☐ asthma ☐ emphysema ☐ **none**

Gastrointestinal: ☐ abdominal pain ☐ abdominal bloating ☐ vomiting ☐ constipation ☐ diarrhea ☐ incontinence ☐ rectal bleeding ☐blood in stool ☐ rectal pain ☐ rectal discharge ☐ narrow stool ☐ gallstones ☐ jaundice ☐ **none**

Genitourinary: ☐ blood in urine ☐ pain with urination ☐ urinary tract infections ☐ kidney disease ☐ **none**

Endocrine: ☐ diabetes ☐ tremors ☐ fatigue ☐ palpitations ☐ adrenal disease ☐ hyperthyroidism, ☐ hypothyroidism ☐ **none**

Hematologic/Lymphatic: ☐ enlarged lymph nodes ☐ easy bruising ☐ bleeding problems ☐ **none**

Family History: *(parents, siblings, children. List all family members with heart disease, cancer, polyps?)*

____

____

____☐ **none**

Social History: Marital Status ☐ Married ☐Single ☐ Other__________________________

Alcohol ☐ no ☐ Socially only ☐ Amount __________

Cigarettes ☐ no ☐ yes packs/day ______________

Non- Prescription drug use? ☐yes ☐ no if yes, type used _________________________________

Illegal drug use? (for medical purposes only, will remain CONFIDENTIAL) ☐ yes ☐ no

If yes, type used_______________________________ and frequency? ___________________________________

Have you had a colonoscopy? ☐ no ☐ yes ☐ date/ results __________________________________

Patients Name ____ **Today's Date:** ____________

(For Physician Use Only-Documentation must be detailed)

PMH/FH/Social Hx: ☐ reviewed and confirmed by physician
ROS: ☐ reviewed and supplemented by physician

REVIEW OF SYSTEMS

(Indicate ALL systems that are discussed including ones that are negative. Extended 2-9 systems, Complete 10+ systems)

☐ Constitutional ____________________________
☐ Eyes ___________________________________
☐ Ears, Nose, Mouth/Throat ____________________
☐ Integumentary ____________________________
☐ Neurological _____________________________
☐ Psychiatric ______________________________
☐ Musculoskeletal ___________________________
☐ Cardiovascular ___________________________
☐ Respiratory ______________________________
☐ Gastrointestinal ___________________________
☐ Genitourinary _____________________________
☐ Endocrine _______________________________
☐ Hematologic/Lymphatic ____________________
☐ Allergic/Immunologic _____________________
☐ All systems other than what is marked above have also been reviewed and are negative.

NOTES: ____
____
____

HISTORY

CC:____

☐ obtained history from ___________________________.

☐ unable to obtain history from patient or family members because ___________________________.

History of Present Illness: (location, quality, severity, timing, duration, context, modifying factors, signs/symptoms)(Brief 1-3, Extended 4+)

Patients Name ____ **Today's Date:** ____________

PHYSICAL

VITALS: P________ T_________ BP_________ WT_________ HT_________ Resp ___________ (4/6)

Constitutional: ☐Vitals Reviewed General Appearance ____

Body Area/Organ System	Specifics	Normal or not examined (NA)	Positive Findings/Comments
EYES	Conjunctiva/Lids Pupils		
ENT	External ear Oropharynx Neck Thyroid		
RESPIRATORY	Respiratory effort Percussion of chest Palpation of chest Auscultation of lungs		
CARDIOVASCULAR	Palpation of heart Auscultation of heart Carotids Radial pulses Edema/varicosities		
CHEST (BREAST)	Inspection of Breasts Palpation of Breasts		
GASTROINTESTINAL	Abdomen Liver and Spleen Umbilical Hernia Inguinal Hernia Anus, perineum, rectum		
GU (MALE)	Scrotal contents Penis Rectal/prostate		
GYN (FEMALE)	External Genitalia Vagina		
LYMPHATICS	Neck Axillae Groin Other		
MUSCULOSKELETAL	Inspection/plapation Range of motion		
SKIN	Temperature, Color Turgor, appearance		
NEUROLOGIC	Alert and Oriented x 3		
PSYCHIATRIC	Mood and affect		

Patients Name ____ **Today's Date:** ____________

Tests Ordered/Reviewed

Tests Ordered/Reviewed: *(if personally viewed film, CT, x-ray, etc. please indicate by checking "visualized image" and writing what you viewed and a brief impression)*

Labs	☐	__________________________	Scope	☐	__________________________
X-Rays	☐	__________________________	Visualized image	☐	__________________________
EKG, Stress Thal.	☐	__________________________	Pathology	☐	__________________________
Ordered records	☐	__________________________	Reviewed records	☐	__________________________

Anoscopy:

Proctoscopy:

Diagnosis:
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

Plan:
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

Physicians called and case discussed:

Informed Consent Given for the Following Procedure: __________________________ **yes** ☐

The Procedure was reviewed with the patient including but not limited to the following complications:

Hernia: Pain, bleeding, recurrence, enterotomies____**yes** ☐

Colonoscopy: Perforation, bleeding, pain ___**yes** ☐

Colon: Heart attack, Pulmonary embolus, DVT, bleeding, wound infection, hernia, anastomotic leak, intra-abdominal abscess, possible stoma and conversion to open procedure if the operation was started laparoscopically, reoperation, bleeding__**yes** ☐

Rectal: Heart attack, Pulmonary Embolus, DVT, bleeding, wound infection, hernia, anastomotic leak, intra-abdominal abscess, conversion to open procedure if the operation was started laparoscopically, possible stoma, incontinence, reoperation__ **yes** ☐

Anal: Heart attack, Pulmonary Embolus, DVT, bleeding, wound infection, incontinence, reoperation__ **yes** ☐

Physician Signature: ________________________________Date: ______________________