



Physicians:
Harold H. Sullivan, MD, MPH

Nurse Practitioners:
Jaime M. Hare, MS, FNP-C
Michelle S. True, MS, FNP-C
Pamela R. Fox, MS, FNP-C

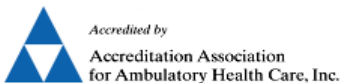
Casco Bay Gastroenterology, LLC
Casco Bay Endoscopy Center

INTAKE RECORD

PLEASE COMPLETE AND RETURN AS SOON AS POSSIBLE

Name		Date	
Date of Birth	Age	Male / Female	Height
Primary Phone #	Secondary #	Other #	
Occupation		Marital Status	
Do you have a Living Will/Advance Directive? Yes / No If yes, please bring a copy to your appointment.			
Please list ALL healthcare Providers whom you would like to receive a copy of your report:			
Please list ANYONE with whom we may discuss your care:			
Primary Complaint:		Please list all current medications:	
		Name	Dosage
			Frequency
Please circle all that apply to you:			
Heart Disease / Heart Valve Replacement: Yr:			
High Blood Pressure / Diabetes: diet or medication controlled			
Cardiac Stent / Pacemaker: Type:			
Respiratory Problems / Orthopedic joint replacement: Yr:			
Cancer / Liver Disease / Asthma / Oxygen Therapy		Do you take aspirin or aspirin products? Yes / No	
Seizures / A.I.C.D. / Chronic Constipation		If yes, why?	
Glaucoma		Do you take blood thinners? Yes / No	
Dentures / Loose Teeth / Hearing Aids / Contact Lenses / Glasses		If yes, why?	
		Do you take pain medication daily? Yes / No	
Physical Disabilities: Yes / No If yes, please explain:		Family History	
Allergies/Type of Reaction:		Please circle and give relationship of all that apply to you and/or any relative:	
		Colon Cancer	Colon Polyps
		Liver Disease	Ulcers
		Pancreatitis	Alcoholism
Surgeries/Dates:		Crohn's Disease	Colitis
Other Medical Problems:		Other type of Cancer:	
		Autoimmune Disorder:	
		Please note any illnesses. If deceased, please give age and cause of death:	
Please circle and describe your tobacco habits:		Father	
Cigarettes / Cigars / Pipe / Chew		Mother	
Never	Packs per day:	Brothers	
Year Quit:	Year started:	Sisters	
How many alcoholic beverages? (beer, wine, liquor)		Spouse	
None	Drinks per week	Child	
Drinks per day	Drinks on weekends	Child	

Office Use Only: MD/NP Signature _____ Date _____





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Patient Name _____ Date of Birth _____ Date _____

ENDOSCOPY HISTORY

Have you ever...
had a Colonoscopy? Yes / No If yes, when? _____ where? _____ by whom? _____
had polyps removed? Yes / No _____
had an upper Endoscopy? Yes / No _____
had a "difficult" procedure? Yes / No If yes, why? _____
had difficulty with any sedation? Yes / No If yes, how? _____

REVIEW OF SYSTEMS (Please check Yes or No for all items)

<p>Constitutional</p> <p>Recent weight change ___No ___Yes</p> <p>Fever ___No ___Yes</p> <p>Fatigue ___No ___Yes</p> <p>Eyes</p> <p>Blurred vision ___No ___Yes</p> <p>Glaucoma ___No ___Yes</p> <p>ENT</p> <p>Hearing loss ___No ___Yes</p> <p>Ringing in ears ___No ___Yes</p> <p>Mouth sores ___No ___Yes</p> <p>Cardiovascular</p> <p>Chest pain ___No ___Yes</p> <p>Shortness of breath ___No ___Yes</p> <p>Swelling of ankles ___No ___Yes</p> <p>Respiratory</p> <p>Chronic cough ___No ___Yes</p> <p>Spitting up blood ___No ___Yes</p> <p>Wheezing ___No ___Yes</p> <p>Skin</p> <p>Rash ___No ___Yes</p> <p>Itching ___No ___Yes</p>	<p>Gastrointestinal</p> <p>Poor appetite ___No ___Yes</p> <p>Difficulty swallowing ___No ___Yes</p> <p>Heartburn ___No ___Yes</p> <p>Nausea or Vomiting ___No ___Yes</p> <p>Bloating ___No ___Yes</p> <p>Belching ___No ___Yes</p> <p>Regurgitation ___No ___Yes</p> <p>Constipation ___No ___Yes</p> <p>Diarrhea ___No ___Yes</p> <p>Abdominal pain ___No ___Yes</p> <p>Recent change in bowel habits ___No ___Yes</p> <p>Rectal bleeding ___No ___Yes</p> <p>Black, tarry stools ___No ___Yes</p> <p>Neurological</p> <p>Headaches ___No ___Yes</p> <p>Seizures ___No ___Yes</p> <p>Strokes ___No ___Yes</p> <p>Numbness ___No ___Yes</p>	<p>Genitourinary</p> <p>Burning with urination ___No ___Yes</p> <p>Blood in urine ___No ___Yes</p> <p>Endocrine</p> <p>Heat/cold intolerance ___No ___Yes</p> <p>Excessive thirst/urination ___No ___Yes</p> <p>Musculoskeletal</p> <p>Joint pain or swelling ___No ___Yes</p> <p>Back pain ___No ___Yes</p> <p>Muscle pain ___No ___Yes</p> <p>Psychiatric</p> <p>Memory loss or confusion ___No ___Yes</p> <p>Depression ___No ___Yes</p> <p>Hematological</p> <p>Bleeding or bruising tendency ___No ___Yes</p> <p>Anemia ___No ___Yes</p> <p>Blood transfusion ___No ___Yes</p> <p>If so, what year? _____</p> <p>Are you pregnant? ___No ___Yes</p>
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HEPATITIS SCREENING

Have you ever had Hepatitis? ___No ___Yes	Do you have any of the following risk factors for Hepatitis? ___No ___Yes (Please check all that apply)
Have you ever been screened for Hepatitis? ___No ___Yes	<input type="checkbox"/> Injection drug use (even once)
Have you ever had yellow discoloration of the skin or eyes? ___No ___Yes	<input type="checkbox"/> Job exposure to blood/body fluids
	<input type="checkbox"/> Previous blood transfusion/organ transplant
	<input type="checkbox"/> Partner (s) with risk factors
	<input type="checkbox"/> Multiple sexual partners
	<input type="checkbox"/> Unsafe medical practices
	<input type="checkbox"/> Needle sticks
	<input type="checkbox"/> Tattoos/body piercings
	<input type="checkbox"/> Household member with Hepatitis
	<input type="checkbox"/> Hemodialysis
	<input type="checkbox"/> Recreational cocaine use

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