Dr. Thomas E. Ducker, M.D. - Gastroenterology

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PATIENT INFORMATION: (Please print FILL IN *ALL* BLANKS COMPLETELY)

Patient Name: ____ Date of Birth: _________________________________

Patient Address: ____

City: _______________________________________ State: ____________________________ Zip: _______________________

Home Phone: ______________________ Cell Phone: ______________________ Work Phone: __________________________

Email Address: ____

Sex: Male / Female   Marital Status: M / S / D / W / Other   Race & Ethnicity: __________________________________

Driver's License: __________________________________ Social Security: ____

Employer/Retired: ____

Spouse Name: ____________________________________ Phone: _________________________DOB:___________________

Preferred **PHARMACY**: ____

Primary Dr.: ____Referring Dr.: ____

IN CASE OF EMERGENCY:

Name: ____________________________________ Relationship: ________________________ Phone: _______________________

PERSON(S) AUTHORIZED TO RECEIVE MEDICAL AND/OR BILLING INFORMATION:

Name: ____________________________________ Relationship: _________________________ Phone: ______________________

Name: ____________________________________ Relationship: _________________________ Phone: ______________________

INSURANCE INFORMATION: *(fill in ALL blanks)*

PRIMARY Insurance:

____

Policy Holder Name/Date of Birth:

____

Relationship to Patient: _____________________________

Policy Holder Social: ___________________________________

Policy Number:_____________________________________

Group ID: ____

SECONDARY Insurance:

____

Policy Holder Name/Date of Birth:

____

Relationship to Patient: _____________________________

Policy Holder Social: ___________________________________

Policy Number:_____________________________________

Group ID: ____

I certify that the information provided is true and accurate to the best of my ability.

Signature: ____ Date: ______________________ Emp___

THOMAS E. DUCKER, M.D. – GASTROENTEROLOGY

PATIENT NAME:____DATE:________________________

Please complete ALL questions. If none or does not apply, write NONE or N/A.

REASON FOR VISIT ____

____

Have you had any allergic or unusual reactions to any medicine, foods, insects or contrast media, or Latex? Please specify what it was and the reaction you had.____

____

Please list **ALL** medications you are currently taking including vitamins, over the counter medications and herbal medications and anything taken only as needed.

Name/Strength   Times per day

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____

Please indicate any of the following medical conditions that apply to you:

A-Fib	Breast Cancer	Gout	GERD
AIDS	Reflux	Bleeding Disorder	Lupus
Anemia	Irritable Bowel Syndrome	Venereal Disease	Mental Illness
Arthritis	Heartburn	Peptic Ulcer	Colon Cancer
Asthma	Emphysema	COPD	Hypothyroid
Colitis or Crohn's disease	Hepatitis (Type)	Ovarian Cancer	
Congestive Heart Failure	Heart Attack	Kidney Stones	
Fibromyalgia	Depression	Colon Polyps	
High Cholesterol	Diabetes	High Blood Pressure	
Hyperthyroid	Cirrhosis of Liver	Migraines	
Seizures/Epilepsy	Stroke	Prostate Cancer	

Other Cancers or diseases/Specify:____

____

NAME:____ DATE:___________________________

Please Indicate Past Surgeries:

Appendectomy	Yes	No	
Breast Biopsy	Yes	No	Specify Type____
Colon	Yes	No	Specify Type____
Gallbladder	Yes	No	
Hernia Repair	Yes	No	Specify type ____
Hysterectomy	Yes	No	
Mastectomy	Yes	No	Specify side ____
Tonsillectomy	Yes	No	

Other Surgeries: ____
____
____

Do You Smoke?	Yes	No	If no, have you ever been a smoker? Yes No
Do you use smokeless tobacco?	Yes	No	have you ever? Yes No
Do you drink Alcohol?	Yes	No	Daily Occasional Rarely Never Previously
Have you used recreational drugs?	Yes	No	IV Intranasal Other____________
Do you drink caffeine?	Yes	No	If yes, how much? ____________________________

Are there any diseases that run in your family?

Cirrhosis of Liver:	father	mother	brother	sister	son	daughter	other_______
Colitis or Crohn's:	father	mother	brother	sister	son	daughter	other_______
Heart disease:	father	mother	brother	sister	son	daughter	other_______
High Blood Pressure:	father	mother	brother	sister	son	daughter	other_______
High cholesterol:	father	mother	brother	sister	son	daughter	other_______
Breast Cancer:	father	mother	brother	sister		daughter	other_______
Colon Cancer:	father	mother	brother	sister	son	daughter	other_______
Colon Polyps:	father	mother	brother	sister	son	daughter	other_______
Diabetes:	father	mother	brother	sister	son	daughter	other_______
Lung Cancer:	father	mother	brother	sister	son	daughter	other_______
Uterine Cancer:		mother		sister		daughter	other_______
Ovarian Cancer:		mother		sister		daughter	other_______
Prostate Cancer:	father		brother		son		other_______
Other cancers/diseases:							
____________________	father	mother	brother	sister	son	daughter	other_______
____________________	father	mother	brother	sister	son	daughter	other_______

What was your highest level of education? ____
Do you live alone? ________________________ If No, who do you live with? ___________________________

PATIENT NAME____ DATE: ____________________________

REVIEW OF SYMPTOMS: Please indicate any symptoms you are having **NOW**.

CONSTITUTIONAL: Fever Chills Chronic fatigued I don't sleep well at night

HEMATOLOGICAL/LYMPHATIC: Easy bruising Easy bleeding Any unusual lumps or bumps noted

ALLERGY/IMMUNOLOGY: Allergy to foods Allergy to molds Allergy to pollen Allergy to Insects

ENDOCRINE: Frequent urination Abnormal thirst Poor tolerance to heat / cold Weight loss Weight gain

EYES: Recent vision change Double vision

ENT/MOUTH: Mouth sores Hoarseness Poor Hearing Trouble swallowing Painful swallowing Food sticking on occasion Jaw pain/popping with chewing

CARDIOVASCULAR: Chest pain Chest tightness Abnormal/skipping heartbeats(Palpitations) Swelling legs Swelling hands Pain in legs soon after exercising Chest heaviness

RESPIRATORY: Shortness of breath at rest Short of breath with exercise Short of breath when lying flat Awaken at night gasping for breath Cough up blood Sore throat Dry cough
Wet cough Nasal congestion I have been told I snore excessively

GASTROENTESTINAL: Abdominal bloating Nausea Diarrhea Vomiting Constipation Vomiting of blood or "coffee ground" material Recent change in bowel habits Blood in stool Diarrhea alternating with constipation Abdominal pain Dark or tarry stools White stools Blood noted on toilet paper when wiping Painful rectum Hemorrhoid problem Trouble holding stool Change in caliber of stool Heartburn

GENITOURINARY: Discomfort or pain with urination Blood in urine Dark urine Trouble holding urine Genital discharge Genital lumps or sores Difficulty starting urine stream

MUSCULOSKELETAL: Neck pain Back pain Joint pain Joint stiffness Joint swelling

NEUROLOGICAL: Weakness of one arm/hand or leg Trouble talking Drooling problem Dizziness Seizures Weakness of one side of your face

SKIN: New skin rash Skin cancer Psoriasis

PSYCHOLOGICAL: Anxiety Depression Thoughts of hurting yourself Thoughts of hurting others I need help coping with my stress Trouble staying asleep at night Falling asleep anywhere/anytime

CANCER SCREENING HISTORY:
Have you ever had a screening exam for cancer, such as Colonoscopy EGD Barium enema Sigmoidoscopy Mammogram? If so, when was last test done and by whom?____
____