MICHELLE RANDOLPH MD PC

AKGIMD.COM

2741 Debarr #402 Anchorage AK 99508

(T)907-531-5213 (F)907-531-5013

PATIENT INFORMATION			
LAST NAME:	FIRST NAME:		MIDDLE INITIAL:
SEX: ☐MALE ☐FEMALE	SSN:	DATE OF BIRTH:	MARITAL STATUS:
ADDRESS:			
PRIMARY PHONE NUMBER:	SECONDARY PHONE NUMBER:		
OK TO LEAVE DETAILED MESSAGE IN VOICE MAIL? ☐YES ☐NO			
EMAIL ADDRESS:	OK TO EMAIL TEST RESULTS? ☐YES ☐NO		
OCCUPATION:	EMPLOYER:		
PRIMARY CARE PROVIDER:			
PREFERRED PHARMACY:	PHARMACY ADDRESS:		
HEALTH INSURANCE	☐ (SELF PAY)		
PRIMARY INSURANCE			
INSURANCE COMPANY:	SUBSCRIBER NAME:		
ID NUMBER:	GROUP NUMBER:		
EMPLOYER:	SUBSCRIBER DOB:	RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐SPOUSE ☐PARENT	
SECONDARY INSURANCE			
INSURANCE COMPANY:	SUBSCRIBER NAME:		
ID NUMBER:	GROUP NUMBER:		
EMPLOYER:	SUBSCRIBER DOB:	RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐ SPOUSE ☐PARENT	
EMERGENCY CONTACT INFORMATION			
NAME:	RELATIONSHIP: ☐SPOUSE ☐PARENT ☐PARTNER ☐FRIEND	PHONE NUMBER:	

ALL CO-INSURANCE PAYMENTS ARE DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT I AM RESPONSIBLE FOR OBTAINING A REFERRAL FROM MY PRIMARY CARE PHYSICIAN IF ONE IS REQUIRED.
I ACCEPT FINANCIAL RESPONSIBILITY FOR ALL ACCOUNT BALANCES OVER 30 DAYS. ANY ACCOUNTS THAT ARE REFERRED FOR COLLECTION WILL BE CHARGED REASONABLE COLLECTION FEES AND ATTORNEY FEES.
I AUTHORIZE THE DOCTOR TO RELEASE INFORMATION TO MY INSURANCE COMPANY. I AUTHORIZE ALL INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR.

_____ _____
PATIENT SIGNATURE DATE

CHIEF COMPLAINT:

☐ ABDOMINAL PAIN
☐ COLONOSCOPY SCREENING
☐ NAUSEA
☐ VOMITING
☐ STOMACH FULLNESS
☐ BLOOD IN STOOL
☐ LIVER DISEASE
☐ BLOATING
☐ FECAL INCONTINENCE
☐ CONSTIPATION
☐ HEARTBURN or REGURGITATION
☐ WEIGHT LOSS
☐ LOSS OF APPETITE
☐ ABNORMAL IMAGING (CT, ultrasound, xray)
☐ DIARRHEA
☐ DIFFICULTY SWALLOWING
☐ PAINFUL SWALLOWING
☐ ABNORMAL BLOOD TEST
☐ OTHER:
_____
_____

PLEASE DESCRIBE SYMPTOMS:

PREVIOUS TESTING- PLEASE INCLUDE DATES AND RESULTS IF AVAILABLE. PLEASE INCLUDE COPIES OF PREVIOUS UPPER ENDOSCOPY AND COLONOSCOPY REPORTS WITH PATHOLOGY RESULTS IF POSSIBLE

☐ BLOOD TEST
☐ CAPSULE ENDOSCOPY
☐ CT SCAN
☐ ENDOSCOPY
☐ COLONOSCOPY
☐ MRI
☐ STOOL TEST
☐ URINE TEST
☐ ABDOMINAL ULTRASOUND
☐ SIGMOIDOSCOPY
☐ NONE
☐ OTHER

CURRENT & PAST MEDICAL PROBLEMS

☐ ANXIETY/DEPRESSION
☐ANESTHESIA COMPLICATION
☐ ASTHMA
☐ ATRIAL FIBRILATION
☐ CANCER. TYPE: _____
☐ CHRONIC BRONCHITIS/ EMPHYSEMA
☐ COLON POLYP
☐ CONGESTIVE HEART FAILURE
☐ CORONARY ARTERY DISEASE/ANGINA
☐ DIABETES MELLITUS
☐ DIVERTICULOSIS
☐ GERD (REFLUX)
☐ H. PYLORI/GASTRITIS
☐ HEMORRHOIDS
☐ HIGH CHOLESTEROL/ TRIGLYCERIDES
☐ HYPERTENSION
☐ IRRITABLE BOWEL SYNDOME
☐ KIDNEY STONE
☐ KIDNEY INSUFFICIENCY
☐ OSTEOPOROSIS/ OSTEOPENIA
☐ PEPTIC ULCER
☐ SEIZURE
☐ SHORTNESS OF BREATH
☐ SLEEP APNEA
☐ STROKE
☐ THYROID PROBLEM
☐ OTHER:

PAST SURGICAL HISTORY:

☐NONE

SURGERY:	DATE:	SURGERY:	DATE:
☐ APPENDECTOMY	_____	☐ INTESTINAL/ABDOMINAL	_____
☐ BREAST	_____	☐ TONSILLECTOMY	_____
☐ GALLBLADDER	_____	☐ STOMACH/DUODENAL ULCER	_____
☐ HERNIA REPAIR	_____	☐ OTHER	_____
☐ HYSTERECTOMY/OVARIES	_____		_____

HOSPITALIZATIONS OTHER THAN SURGERY

DETAILS	DATE

ALLERGIES TO MEDICATION – INCLUDE LATEX/TAPE, IODINE AND SERIOUS ADVERSE REACTIONS

MEDICATIONS	REACTIONS

CURRENT MEDICATIONS/SUPPLEMENTS INCLUDING OVER THE COUNTER MEDICATIONS

NAME	DOSE/FREQUENCY	NAME	DOSE/FREQUENCY

FAMILY HISTORY- INCLUDE AGE OF DIAGNOSIS

	FATHER	MOTHER	BROTHER	SISTER	GRANDPARENT
ESOPHAGEAL CANCER	☐	☐	☐	☐	☐
BREAST CANCER	☐	☐	☐	☐	☐
LIVER DISEASE	☐	☐	☐	☐	☐
GALLBLADDER DISEASE	☐	☐	☐	☐	☐
STOMACH CANCER	☐	☐	☐	☐	☐
SMALL BOWEL CANCER	☐	☐	☐	☐	☐
CELIAC DISEASE	☐	☐	☐	☐	☐
COLITIS/CROHN'S DISEASE	☐	☐	☐	☐	☐
COLON CANCER	☐	☐	☐	☐	☐
COLON POLYP	☐	☐	☐	☐	☐
UTERINE/OVARIAN CANCER	☐	☐	☐	☐	☐
RENAL/URETERAL CANCER	☐	☐	☐	☐	☐

OTHER:

SOCIAL HISTORY

SMOKING STATUS	☐ NEVER	☐ CURRENT/EVERY DAY	☐ CURRENT/SOME DAYS	☐ FORMER
ALCOHOL USE	☐ NO ☐ YES YEAR QUIT:_____	PER WEEK:_____	NUMBER OF YEARS:__	
RECREATIONAL DRUG USE	☐ NO ☐ YES YEAR QUIT:_____	DRUGS USED:_____		
MARITAL STATUS	☐SINGLE	☐MARRIED	☐DIVORCED	☐WIDOWED
CHILDREN	☐NONE	☐1 CHILD	☐2 CHILDREN	☐3 OR MORE CHILDREN
EXCERCISE	☐NO ☐YES	TYPE:_____	FREQUENCY:_____PER WEEK	

ADDITIONAL SYMPTOMS:

GASTROINTESTINAL
□ ABDOMINAL PAIN
□ BLOATING/GAS
□ BLOOD IN STOOL OR ON TOILET PAPER
□ CIRRHOSIS
□ DIFFICULTY SWALLOWING
□ FILLING UP QUICKLY AT MEALS
□ FLUID IN ABDOMEN
□ GALLSTONES
□ HEARTBURN/REGURGITATION
□ HEPATITIS A B C
□ INTOLERANCE TO FOODS
□ IRREGULAR BOWEL HABITS
□ JAUNDICE
□ LOSS OF CONTROL OF BOWELS
□ MUCUS IN STOOL
□ NAUSEA AND VOMITING
□ PANCREATITIS

RESPIRATORY/LUNG
□ ASTHMA
□ DIFFICULTY BREATHING
□ PERSISTENT COUGH
□ RESPIRATORY COMPLICATIONS WITH SEDATION
□ SLEEP APNEA/CPAP

ENDOCRINE
□ DIABETES
□ OSTEOPOROSIS OR OSTEOPENIA
□ THRYOID DISEASE

NEUROLOGIC
□ HEADACHES
□ SEIZURES
□ STROKES
□ NUMBNESS
□ WEAKNESS

SKIN
□ ITCHING
□ RASH
□ UNUSUAL HAIR LOSS

CARDIOVASCULAR
□ ABNORMAL HEART RHYTHM
□ CHEST PAIN OR PRESSURE
□ HIGH BLOOD PRESSURE
□ SWELLING IN FEET OR LEGS
□ CORONARY ARTERY DISEASE

GYNECOLOGY
□ ENDOMETROSIS
□ HEAVY PERIODS
□ PREGNANT

PSYCHIATRIC
□ ANXIETY
□ DEPRESSION
□ SUICIDE ATTEMPT

GENERAL
□ DECREASED APPETITE
□ FATIGUE
□ FEVER
□ CHILLS
□ UNEXPECTED WEIGHT GAIN
□ UNEXPECTED WEIGHT LOSS

EYES
□ LOSS OF VISION

ENT
□ HEARING LOSS
□ TINNITUS
□ SINUSITIS/SINUS DRAINAGE
□ SORE THROAT
□ HOARSENESS

RENAL/URINARY/KIDNEY
□ PAINFUL URINATION
□ NIGHTTIME URINATION
□ RENAL FAILURE
□ URINARY TRACT INFECTION

MUSCULOSKELTAL
□ BACK/NECK PAIN
□ JOINT PAIN/ARTHRITIS

BLOOD/LYMPH
□ ANEMIA
□ BRUISE EASILY
□ PAST BLOOD TRANSFUSION
□ SWOLLEN/TENDER LYMPH NODES

IS THERE ANYTHING ELSE THAT WE SHOULD KNOW: