**MICHELLE RANDOLPH MD PC**
**2741 DEBARR Suite 402 ANCHORAGE AK 99508**
**(T)907-222-5077 (F)907-222-5088**
**WWW.AKGIMD.COM**
**Monday-Friday 8am to 4pm**

**PLEASE INCLUDE A COPY OF YOUR ID AND INSURANCE CARD (FRONT AND BACK) ALONG WITH THIS PAPERWORK. THANK YOU.**

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| PATIENT INFORMATION | | | |
|---|---|---|---|
| LAST NAME: | FIRST NAME: | MIDDLE INITIAL: | |
| SEX: ☐MALE ☐FEMALE | SSN: | DATE OF BIRTH: | MARITAL STATUS: |
| ETNICITY: | ADDRESS: | | |
| CITY | STATE | ZIP CODE | |
| PRIMARY PHONE NUMBER: | SECONDARY PHONE NUMBER: | | |
| OK TO LEAVE DETAILED MESSAGE IN VOICE MAIL? ☐YES ☐NO | | | |
| EMAIL ADDRESS: | | | |
| OCCUPATION: | EMPLOYER: | | |
| PRIMARY CARE PROVIDER: | REFERRING 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 | |
| YOUR RIGHT TO PRIVACY | | | |
| PATIENTS FULL NAME | | | |
| WE UNDERSTAND YOU MAY HAVE CONCERNED RELATIVES OR SIGNIFICANT OTHERS. PLEASE LIST NAMES OF THOSE PEOPLE THAT WE MIGHT SHARE YOUR MEDICAL INFORMATION WIH. WITHOUT YOUR WRITTEN CONSENT, THIS INFORMATION WILL NOT BE RELEASED. | | | |
| NAME | PHONE | RELATIONSHIP | |
| NAME | PHONE | RELATIONSHIP | |
| NAME | PHONE | RELATIONSHIP | |

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 | ☐ EXPLAIN: | | | | |

## 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<br>☐ 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

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

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

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

ENDOCRINE
□ DIABETES
□ OSTEOPOROSIS OR OSTEOPENIA
□ THRYOID DISEASE

GYNECOLOGY
□ ENDOMETROSIS
□ HEAVY PERIODS
□ PREGNANT

PSYCHIATRIC
□ ANXIETY
□ DEPRESSION
□ SUICIDE ATTEMPT

□ 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: