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:		RACE:	
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:		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	
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	☐ 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 ☐ 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: