VITALY A. FISHBEIN, M.D., F.A.C.G.
Diplomate American Board of Gastroenterology

401 Pleasant Valley Way, West Orange, NJ 07052 • Tel: (973) 736-1112 Fax: (973) 736-5590 • www.gastrocure.com

☐ **Pre-Endoscopy Intake**

Patient Name: _____

Date of Birth: _____ **Age:** _____ **Wt:**_____ **Ht:**_____

Procedure: _____

Dx: _____

Procedure Date: _____

Place: _____

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DO YOU HAVE A HISTORY OF? **Patient Name:**_____

Cardiac Problems:

Yes	No		
☐	☐	High Blood Pressure	
☐	☐	Valve Replacement	Date of surgery: _____
☐	☐	Heart Murmur/Palpitations	
☐	☐	Angina/Heart Attack	Date of: _____
☐	☐	Pacemaker	Date of placement: _____
☐	☐	AICD (defibrillator)	Date of placement: _____
☐	☐	Bypass or angioplasty	Date of surgery: _____
☐	☐	Swelling of Extremities	
☐	☐	Arrythmia	

Other: _____

Respiratory Problems:

Yes	No	
☐	☐	Asthma
☐	☐	Difficulty Breathing
☐	☐	Sleep Apnea

Other: _____

Endocrine Problems:

Yes	No	
☐	☐	Diabetes
☐	☐	Thyroid Problems

Mental Status:

Yes	No	
☐	☐	Depression
☐	☐	Confusion
☐	☐	Anxiety
☐	☐	Panic Disorders

Liver/Gallbladder Problems:

Yes	No	
☐	☐	Hepatitis A B C
☐	☐	Cirrhosis/liver Disease
☐	☐	Gallbladder Disease/surgery

Other: _____

Blood Disorders:

Yes	No	
☐	☐	Anemia
☐	☐	Clotting Disorders
☐	☐	Bruising

Other: _____

Kidney/Prostate Problems:

Yes	No	
☐	☐	Kidney Dysfunctions
☐	☐	Kidney Failure

Men Only:

☐	☐	Prostate Enlargement
☐	☐	Prostate Cancer

Other: _____

Women Only:

Yes	No	
☐	☐	Hysterectomy
☐	☐	Mastectomy
☐	☐	Lumpectomy R L
☐	☐	Are you pregnant?

Neurological Problems:

Yes	No	
☐	☐	Stroke
☐	☐	Seizure
☐	☐	Headache
☐	☐	Dizziness

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GI Problems:

Yes No
- ☐ ☐ Family History of Colon Cancer

Relationship: _____
- ☐ ☐ Personal History of Colon Cancer
- ☐ ☐ Personal History of Colon Polyps
- ☐ ☐ Diverticulosis/Diverticulitis
- ☐ ☐ Colitis
- ☐ ☐ Crohns
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Rectal Bleeding
- ☐ ☐ Blood in Stool
- ☐ ☐ Abdominal Pain
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Stomach Ulcers
- ☐ ☐ Barretts Disease
- ☐ ☐ Esophageal Strictures
- ☐ ☐ Difficulty Swallowing
- ☐ ☐ Weight Loss
- ☐ ☐ Nausea/Vomiting

Latex Allergy? Yes No
Food Allergy? Yes No
Medication Allergy? Yes No

Surgical History:

_____

_____

_____

Please List ALL Current Prescription Medications:

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		

Primary Care Physician Info:

Name: _____

Phone Number: _____

Last Visit: _____

Pharmacy Info:

Name: _____

Phone Number: _____

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Dr. Fishbein Signature: _____ Date: _____