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:			
HEIGHT:	WEIGHT:		
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
☐ ABNORMAL BLOOD TEST
☐ BLOOD IN STOOL
☐ FECAL INCONTINENCE
☐ DIFFICULT SWALLOWING
☐ COLONOSCOPY SCREENING
☐ CONSTIPATION
☐ VOMITING
☐ WEIGHT LOSS
☐ CROHN'S DISEASE
☐ STOMACH FULLNESS
☐ ULCERATIVE COLITIS
☐ LOSS OF APPETITE
☐ ABNORMAL IMAGING (CT, ultrasound, xray)
☐ BLOOD IN STOOL
☐ EOSINOPHILIC DISEASE
☐ PAINFUL SWALLOWING
☐ LIVER DISEASE
☐ DIARRHEA
☐ BLOATING
☐ 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 (Please explain below)
☐ ASTHMA
☐ ATRIAL FIBRILATION
☐ CANCER. TYPE: _____
☐ CHRONIC BRONCHITIS/ EMPHYSEMA
☐ CHROHN'S DISEASE
☐ 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
☐ SLEEP APNEA
☐ STROKE
☐ THYROID PROBLEM
☐ ULCERATIVE COLITIS
☐ OTHER:

ANESTHESIA COMPLICATION:

_____

_____

PAST SURGICAL HISTORY:

SURGERY:	DATE:	SURGERY:	DATE:
☐ APPENDECTOMY	_____	☐ INTESTINAL/ABDOMINAL	_____
☐ 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 IF NONE PLEASE PUT "N/A"

NAME	DOSE/FREQUENCY	NAME	DOSE/FREQUENCY

FAMILY HISTORY- INCLUDE AGE OF DIAGNOSIS

	FATHER	MOTHER	BROTHER	SISTER	GRANDPARENT
ESOPHAGEAL CANCER	☐	☐	☐	☐	☐
BREAST CANCER	☐	☐	☐	☐	☐
CROHN'S DIEASE	☐	☐	☐	☐	☐
LIVER DISEASE	☐	☐	☐	☐	☐
STOMACH CANCER	☐	☐	☐	☐	☐
CELIAC DISEASE	☐	☐	☐	☐	☐
ULCERATIVE COLITIS	☐	☐	☐	☐	☐
COLON CANCER	☐	☐	☐	☐	☐
COLON POLYP	☐	☐	☐	☐	☐
UTERINE/OVARIAN 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	NEUROLOGIC	GENERAL
☐ ABDOMINAL PAIN	☐ HEADACHES	☐ DECREASED APPETITE
☐ BLOATING/GAS	☐ SEIZURES	☐ FATIGUE
☐ BLOOD IN STOOL OR ON TOILET PAPER	☐ STROKES	☐ FEVER
	☐ NUMBNESS	☐ CHILLS
☐ CIRRHOSIS	☐ WEAKNESS	☐ UNEXPECTED WEIGHT GAIN
☐ DIFFICULTY SWALLOWING		☐ UNEXPECTED WEIGHT LOSS

☐ 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

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

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: