



KIOSK FORM

Please fill out form completely.
 If "None" applies, check the box.
 Bring with you on the day of your
 appointment. Thank You

Patient Name: _____

DOB: _____

Allergies

- | | | | | | |
|----------------------------------|----------------------------------|---------------------------------------|-----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Iodine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Demerol | <input type="checkbox"/> Gluten/Wheat | <input type="checkbox"/> Morphine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other _____ |

PAST OR PRESENT MEDICAL PROBLEMS

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anal Fissure/Fistula | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Migraines | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Milk Intolerance | <input type="checkbox"/> Spine/Back Problems |
| <input type="checkbox"/> Bacterial/Fungal Infection | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Herpes Zoster | <input type="checkbox"/> Mouth Ulcers | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Duodenal Ulcer | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Muscular Aches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Bleeding Gums/Nose | <input type="checkbox"/> Eczema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pain/Burning Throat | <input type="checkbox"/> TB Skin Test Positive |
| <input type="checkbox"/> Blood Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Thyroid Disease - High |
| <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> Esophageal Stricture | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Thyroid Disease - Low |
| <input type="checkbox"/> Brain Cancer | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Hives | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Urinary/Bladder Infection |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Fatty Liver | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Valvular Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Urinary Infections | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Varices of Esophagus/Stomach |
| <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Prostate | <input type="checkbox"/> Weakness/Fatigue |
| <input type="checkbox"/> Cirrhosis of Liver | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Joint Pain/Swelling | <input type="checkbox"/> Rashes | <input type="checkbox"/> Yellow Eyes |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Reflux | <input type="checkbox"/> Other _____ |

SURGERIES/HOSPITALIZATION/PROCEDURES

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Anal Fissure
Fistula Resection | <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Groin Hernia | <input type="checkbox"/> Liver Resection | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Heart Valve
Replacement | <input type="checkbox"/> Lysis of Adhesions | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Back/Neck
Surgery | <input type="checkbox"/> Coronary Bypass | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Obesity Surgery | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Breast Surgery
Benign | <input type="checkbox"/> EGD | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Ovary | <input type="checkbox"/> Uterus |
| <input type="checkbox"/> Breast Surgery
Cancer | <input type="checkbox"/> ERCP | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Prostate | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Esophageal | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Small Bowel Resection | |
| <input type="checkbox"/> Cardiac Surgery | <input type="checkbox"/> Esophageal Stricture
Dilation | <input type="checkbox"/> Kidney | <input type="checkbox"/> Splenectomy | |

SOCIAL HISTORY MARITAL STATUS

- Single Separated Married
 Divorced Widowed

NUMBER OF CHILDREN

- 1 2 3 4 5 6+ None

SOCIAL HISTORY EXERCISE

- I do not exercise I walk I jog I bike
 I swim I golf I do aerobics I lift weights

SOCIAL HISTORY ALCOHOL

- Never More than 2 days/Week
 Rarely Less than 2 days/Week
 Daily I quit using alcohol

SOCIAL HISTORY TOBACCO

- I use tobacco products I have never used tobacco
 I quit using tobacco products

SOCIAL HISTORY OCCUPATION

Occupation _____

- Veteran

SOCIAL HISTORY HOBBIES

Patient Hobbies _____

GASTROINTESTINAL

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Change bowel
habits | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pain with Bowel
Movement | <input type="checkbox"/> Vomiting Blood |
| <input type="checkbox"/> Anal Pain | <input type="checkbox"/> Dairy Intolerance | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Wheat or Gluten Intolera |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rectal Urgency | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Reflux | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Flatulence | <input type="checkbox"/> Mucous in Stool | <input type="checkbox"/> Soiling of Stools/Bowels | |

REVIEW OF SYSTEMS

URINARY

- | | |
|---|---|
| <input type="checkbox"/> None | MALE |
| <input type="checkbox"/> Kidney Disease/Failure | <input type="checkbox"/> Testicle Problem |
| <input type="checkbox"/> Frequent Urinary Infections | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Change in Urinary Frequency | |
| <input type="checkbox"/> Sexually Transmitted Disease | FEMALE |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Heavy periods |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Breast Lump |
| <input type="checkbox"/> Sexual Difficulty | <input type="checkbox"/> Birth Control medication |
| <input type="checkbox"/> Other _____ | |

CARDIOVASCULAR

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Blueness of Extremities | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Poor Circulation |

NERVOLOGICAL

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Changes in Vision
Or Hearing | <input type="checkbox"/> Numbness in Extremities |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Limitation of Movement | <input type="checkbox"/> Other _____ |

CONSTITUTIONAL

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Fever | |
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Other _____ |

EYES

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Visual Decline |
| <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Other _____ |

SKIN

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Cancer – Basal Cell | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Cancer – Melanoma | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cancer – Squamous | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Easy Bruising | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other _____ |

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Shortness of breath when lying flat | |
| <input type="checkbox"/> Shortness of breath when exercising | |
| <input type="checkbox"/> Stent of Artery | |
| <input type="checkbox"/> Valve Disease or Surgery | <input type="checkbox"/> Other _____ |

ENDOCRINE

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> High Triglycerides |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Other _____ | |

PSYCHIATRIC

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Loss of interest in Enjoyable
Activities |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Loss of Sexual Desire |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> None |
| <input type="checkbox"/> Inability to Concentrate | <input type="checkbox"/> Other _____ |

HEMATOLOGIC

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Use of Blood Thinners |
| <input type="checkbox"/> Easy Bruising | |
| <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Other _____ |

THE ENDOSCOPY CENTER

Acknowledgement

I, _____ have reviewed all pages of this kiosk form and the information contained within is correct to the best of my knowledge.

Patient's Signature

Date

