TORRANCE MEMORIAL
HUNT CANCER INSTITUTE

Addendum to Initial Patient Intake Form:
Digestive Care Consultants

Patient Name: _____ **DOB**: _____
(Last) (First) (MI)

Today's Date: _____

Who is your referring doctor? _____ **Phone**: _____

Do you have a cardiologist? Y ☐ N ☐ If yes, pls. provide name: _____

Why are you here today? _____

Have you ever had a Colonoscopy or an Upper Endoscopy before? Y ☐ N ☐ **When?** _____

Results: _____

Health History:	**YES**
Bleeding gums……..	☐
Cold intolerance……...	☐
Dental problems……...	☐
Difficulty lying on Left side……..	☐
Ear pain……	☐
Heat intolerance……	☐
Hoarseness……	☐
Snoring…….	☐
Voice changes……..	☐

Gynecological:

Last period: _____

If pre-menopausal, are periods normal? Y ☐ N ☐

Age at menopause (if applicable): _____

Number of: Pregnancies _____
Deliveries _____
Miscarriages _____

Patient Signature: _____**Date**: _____

If completed by someone other than patient:

Name: _____ **Relationship**: _____