LEO TREYZON MD 8631 W. 3rd St. #1015-E Los Angeles, CA 90048 P 310-652-4472 F 310-358-2266 

FOR OFFICE USE ONLY ACCOUNT # _____ DATE OF VISIT _____

## PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____ DATE OF BIRTH (MM/DD/YYYY) _____

SEX ☐ Male ☐ Female AGE _____ SOCIAL SECURITY # _____ ☐ _____ DRIVER'S LICENCE # _____

ADDRESS _____
Street City State Zipcode

MOBILE PHONE NUMBER _____ EMAIL ADDRESS _____

OTHER (HOME/ WORK) NUMBER _____ PREFERRED CONTACT METHOD: ☐ Phone ☐ Email

FAX NUMBER _____ Would you like us to email you a copy of your test results? ☐ Yes ☐ No

OCCUPATION _____ Business Name/ Address _____

REFERRED BY
Name _____ Phone Number _____ Fax Number _____
Address _____

PRIMARY CARE MD
Name _____ Phone Number _____ Fax Number _____
Address _____

PREFERRED PHARMACY
Name _____ Phone Number _____ Fax Number _____
Address _____

## PERSONAL INSURANCE INFORMATION — Must be completed for billing.

PRIMARY
Insurance Company _____ Subscriber _____
Insurance Company Address _____ Employer _____
Group Number _____ ID Number _____ Plan Number _____

SECONDARY
Insurance Company _____ Subscriber _____
Insurance Company Address _____ Employer _____
Group Number _____ ID Number _____ Plan Number _____

## EMERGENCY CONTACT INFORMATION — Please list an individual who is NOT living with you.

Name of Friend, Relative, Guardian or Parent _____ Relationship _____ Phone Number _____

## AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Leo Treyzon MD to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance bills.

_____ Patient's Signature

_____ Insured's Signature

Last Name _____ First Name _____ Middle Name _____ DATE OF BIRTH (MM/DD/YYYY) _____

Age _____ Date of Visit _____ Referred By _____ Primary Care Physician _____

**Chief Complaint** – Main Reason for Visit

- ☐ abdominal pain
- ☐ weight loss or poor appetite
- ☐ constipation
- ☐ blood in stool
- ☐ colonoscopy screening
- ☐ gas, bloating, or distension
- ☐ diarrhea, urgency, or incontinence
- ☐ other - Please explain.
- ☐ nausea, vomiting, or filling up quickly at meals
- ☐ reflux, heartburn, regurgitation, or indigestion
- ☐ difficulty swallowing or painful swallowing
- ☐ problems with liver, gallbladder, or pancreas
- ☐ lactose or other food intolerance
- ☐ abnormal x-ray or blood test

**History of Present Illness** – Please describe the nature of your problem in the space below.

_____

_____

_____

_____

- How long have you noticed the problem? _____
- Where is the symptom located? _____
- Is it steady or does it come and go? _____
- Does it occur day or night, or before or after meals? _____
- What does it feel like? (sharp, burning, cramping, dull, full, etc.) _____
- What makes it better and what makes it worse? _____
- Rate the severity of the problem. (1 mildest - 10 most severe) _____
- Does it seem to be improving or worsening over time? _____
- What other symptoms do you associate with your main problem? _____
- How disabling is the problem? (Minimal, concerning, somewhat disruptive, extremely uncomfortable, debilitating) _____

**HEALTH CONCERNS**

- Is there a particular test you would like? _____
- Is there a particular diagnosis that you want to investigate? _____
- Is there a particular concern that you have? (even far-fetched) _____

**Previous Testing** – Please include dates. ☐ none

- ☐ blood tests
- ☐ stool tests
- ☐ urine tests
- ☐ breath tests
- ☐ other _____
- ☐ CT scan
- ☐ MRI
- ☐ abdominal ultrasound
- ☐ pelvic/ vaginal ultrasound
- ☐ upper endoscopy
- ☐ colonoscopy
- ☐ sigmoidoscopy
- ☐ wireless capsule endoscopy
- ☐ consultation with other doctors or nutritionists (Please list.) _____

**Previous Treatments** ☐ none

☐ Medications Tried for This Problem _____

☐ Herbs/ Supplements Tried for This Problem _____

☐ Dietary Modifications Tried for This Problem _____

☐ Probiotics ☐ Acupuncture

☐ Other _____

**Diet**

What is your current diet? _____

What are your food intolerances/ trigger foods? (Sugar, caffeine, spicy, other) _____

**Height** _____ **Weight** _____

**Current & Past Medical Problems** ☐ none

| | | |
|---|---|---|
| ☐ anxiety/ depression | ☐ diverticulosis | ☐ kidney insufficiency |
| ☐ asthma | ☐ GERD (reflux) | ☐ osteoporosis or osteopenia |
| ☐ atrial fibrilation/ other rhythm disturbance | ☐ H. pylori/ gastritis | ☐ peptic ulcer |
| ☐ chronic bronchitis/ emphysema | ☐ hemorrhoids | ☐ seizure |
| ☐ colon polyp | ☐ high cholesterol/ triglycerides | ☐ sleep apnea |
| ☐ congestive heart failure | ☐ hypertension | ☐ stroke/ TIA |
| ☐ coronary artery disease/ angina | ☐ irritable bowel syndrome | ☐ thyroid problems |
| ☐ diabetes mellitus | ☐ kidney stone | ☐ other _____ |
| ☐ other _____ | ☐ other _____ | ☐ other _____ |

**Past Surgical History** ☐ none

| Surgery | Details/ Date/ Hospital | Surgery | Details/ Date/ Hospital |
|---|---|---|---|
| ☐ appendectomy | _____ | ☐ other intenstinal/ abdominal | _____ |
| ☐ breast | _____ | ☐ tonsillectomy | _____ |
| ☐ gallbladder | _____ | ☐ stomach/ duodenal ulcer | _____ |
| ☐ hernia repair | _____ | ☐ other | _____ |
| ☐ hysterectomy/ ovaries | _____ | | |

**Hospitalizations Other Than Surgery**

| Details | Date/ Hospital |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Most Recent Upper Endoscopy**

| Date | Physician | General Findings |
|---|---|---|
| | | |

**Most Recent Colonoscopy**

| Date | Physician | General Findings |
|---|---|---|
| | | |

**Allergies to Medications** – Include latex/ tape, iodine and serious adverse reactions other than allergy.)

| Medication | Reaction |
|---|---|
| | |
| | |

**Drug Intolerances**

| Medication | Reaction |
|---|---|
| | |
| | |

**Medications** – Include over the counter and herbal products.

| | Name | Dose/ Frequency/ Condition Being Treated | | Name | Dose/ Frequency/ Condition Being Treated |
|---|---|---|---|---|---|
| 1 | | | 6 | | |
| 2 | | | 7 | | |
| 3 | | | 8 | | |
| 4 | | | 9 | | |
| 5 | | | 10 | | |

**Family History** – Include age of diagnosis.

| | FATHER | MOTHER | BROTHER | SISTER | GRANDPARENT/ OTHER RELATIVE |
|---|---|---|---|---|---|
| esophageal cancer | | | | | |
| breast cancer | | | | | |
| liver disease | | | | | |
| hemochromatosis | | | | | |
| gallbladder disease | | | | | |
| stomach cancer | | | | | |
| small bowel cancer | | | | | |
| celiac disease | | | | | |
| colitis/ Crohn's disease | | | | | |
| colon cancer | | | | | |
| colon polyp | | | | | |
| uterine/ ovarian cancer | | | | | |
| renal/ ureteral cancer | | | | | |
| other | | | | | |

## Social History

**Smoking Status** ☐ Never ☐ Current/ Every Day ☐ Current/ Some Days ☐ Former

**Alcohol Use** ☐ No ☐ Yes Year Quit _____ Drinks per Week _____ Number of Years _____

**Recreational Drug Use** ☐ No ☐ Yes Year Quit _____ Drugs Used _____

**Marital Status** ☐ Married ☐ Single ☐ Widowed ☐ Divorced

**Children** ☐ none Name(s) _____ Ages _____

**Excercise** Type _____ Frequency _____

**Occupation** _____ **Employer** _____

## Names of Specialist Physicians Involved In Your Care

**Cardiologist** _____ **Oncologist** _____

**Gynecologist** _____ **Other** _____

**Review of Systems** – Check if you have any of the following and describe further in space below. ☐ none

**Gastrointestinal**
- ☐ heartburn/ regurgitation
- ☐ difficulty swallowing
- ☐ painful swallowing
- ☐ filling up quickly at meals
- ☐ nausea and vomiting
- ☐ abdominal pain
- ☐ irregular bowl habits
- ☐ bloating/ gas
- ☐ incomplete evaculation of bowels
- ☐ symptoms improve with evacuation
- ☐ blood in stool or on toilet paper
- ☐ mucous in stool
- ☐ loss of control of bowels
- ☐ intolerance to milk
- ☐ intolerance to other foods
- ☐ jaundice
- ☐ gallstones
- ☐ hepatitis A, B, C, other
- ☐ cirrhosis
- ☐ fluid in abdomen (ascites)
- ☐ pancreatitis

**Respiratory/ Lung**
- ☐ sleep apnea/ CPAP mask
- ☐ respiratory complications w/ sedation
- ☐ chronic bronchitis/ emphysema
- ☐ difficulty breathing
- ☐ persistent cough
- ☐ asthma

**Endocrine**
- ☐ diabetes
- ☐ thyroid disease
- ☐ osteoporosis or osteopenia

**Neurologic**
- ☐ headaches
- ☐ strokes/ CVA
- ☐ seizures

**Skin**
- ☐ rash
- ☐ itching
- ☐ unusual hair loss

**Cardiovascular**
- ☐ chest pain, pressure, angina
- ☐ coronary artery disease
- ☐ high blood pressure
- swelling in feet or legs
- abnormal heart rhythm
- prostate cancer/ enlarged

**Gynecology**
- ☐ pregnant now?
- ☐ endometriosis
- ☐ heavy periods

**Psychiatric**
- ☐ depression
- ☐ anxiety
- ☐ suicide attempt

**General**
- ☐ decreased appetite
- ☐ unexpected weight loss
- ☐ unexpected weight gain
- ☐ fatigue
- ☐ fever or chills

**Eyes**
- ☐ blind field of vision
- ☐ cataracts

**ENT**
- ☐ hearing loss/ ringing
- ☐ sore throat/ hoarseness
- ☐ sinusitis/ sinus drainage

**Renal/ Urinary/ Kidney**
- ☐ renal failure/ insufficiently
- ☐ electrolyte disturbances
- ☐ difficulty with urination
- ☐ urinary tract infections

**Musculoskeletal**
- ☐ joint pain/ arthiritis
- ☐ back/ neck pain
- ☐ muscle aching/ weakness

**Blood/ Lymph**
- ☐ anemia
- ☐ bruise easily
- ☐ past blood transfusion
- ☐ swollen/ tender lymph node
- ☐ low platelets
- ☐ Coumadin or Lovenox

_____

_____

_____