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

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

_____

_____

_____