____

has an appointment with

GLENN MADOKORO, M.D., F.A.C.G., Inc.

351 Hospital Road, Suite 210 Newport Beach, CA 92663
Telephone: (949) 548-8800

☐ MON. ☐ TUES. ☐ WED. ☐ THURS. ☐ FRI.

______________________ AT ____________ A.M. / P.M.

WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS CANCELLED
OR BROKEN WITHOUT 48 HOURS ADVANCED NOTICE

****Please arrive 15 minutes early.****

****Please bring your ORIGINAL insurance card(s) and driver's license with you.****

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GLENN D. MADOKORO, M.D., F.A.C.G., INC.

NAME: ______________________________
Last, First MI

ADDRESS: ______________________________
Street (no P.O. Boxes, please)

____
City, State Zip code

DATE OF BIRTH: _______/_______/_______
Month Day Year

SOCIAL SECURITY #: ______________________
* Please note we MUST have this to verify your insurance. If you do not wish to provide your SS# it is possible we will not be able to obtain precert from your insurance company.

MARITAL STATUS: S M W SEP D Other Minor

TELEPHONE: ( )_______-__________ HOME
( )_______-__________ WORK
( )_______-__________ CELL
( )_______-__________ FAX
____________________@____________ EMAIL

**Please note which number you prefer to be contacted at.

SPOUSE'S SOC SEC #: ______________________

SPOUSE'S NAME: __________________________

SPOUSE'S DATE OF BIRTH: ______/______/______
Month Day Year

EMERGENCY CONTACT NAME: __________________________

EMERGENCY CONTACT RELATIONSHIP: ____________________

EMERGENCY CONTACT PHONE: ( )_______-__________

REFERRING PHYSICIAN:____________________
doctor / family / friend

Please list names of physicians you wish us to send copies of your reports to:

____
____
____

EMPLOYED BY: __________________________

OCCUPATION: __________________________

NAME OF INS: __________________________
Primary

NAME OF INS: __________________________
Secondary

Please bring your ORIGINAL insurance card(s) and driver's license with you to the appointment.

Name of local pharmacy:____________________
( )_______-__________ Pharmacy # (Voice)
( )_______-__________ Pharmacy # (Fax)

Please note ALL prescriptions are sent electronically by our office via E-prescribe, so please use a pharmacy which is set up for this service

Mail order pharmacy: ______________________
( )_______-__________ (Voice)
( )_______-__________ (Fax)

Please note that we do NOT validate. PAID parking ($1.00 / 30 min) or valet parking ($3) is available. Thank you!

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

DATE: ______/______/______ SIGNATURE: X__________________________________

I authorize Dr. Madokoro to apply for benefits on my behalf for covered services rendered by him, or his order. I request that payment from my insurance company be made directly to Dr. Madokoro. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. I authorize Dr. Madokoro to obtain historical information regarding my prescriptions, and formulary information in order for him to know which medications will be covered under my insurance.

DATE: ______/______/______ SIGNATURE: X__________________________________

It is current policy of this office that:

1. It is the responsibility of the patient to inform us whenever precertification and/or authorization is required prior to any testing that Dr. Madokoro recommends.
   a. To determine if pre-certification is required or
   b. To inform our office far enough in advance so that we may call and obtain authorization.

(More on back)

GLENN D. MADOKORO, M.D., F.A.C.G., INC.
351 HOSPITAL ROAD, SUITE 210
NEWPORT BEACH, CA 92663
(949) 548-8800 (voice)
1-855-324-3537 (fax)

DATE: _____/_____/______

PATIENT: ________________________________,______________________________
Last First

I have been notified by the staff of Dr. Madokoro that he **DOES** accept my insurance:

For: 1. Today's visit
& / or your
2. Colonoscopy / Upper Endoscopy / ERCP /_________________
-please note:
- not all insurances pay for screening colonoscopies
- not all insurances pay for screening colonoscopies at 100% with no deductible
- if you wish to know the amount that will be paid, please request this prior to your initial visit with Dr. Madokoro.

Medicare patient ONLY:

1. If you are on Medicare, please note that while Dr. Madokoro DOES accept Medicare, he does NOT accept assignment, which means Medicare will pay you directly. Once you receive the check for Dr. Madokoro's services CASH the check and write us your own check for the same amount.
2. We may bill you 15% above the allowed amount, many secondary insurances pay this additional amount.

PATIENT SIGNATURE: ____

WITNESS SIGNATURE: ____

(More on back)

Date:______/______/_______

Glenn D. Madokoro, M.D., F.A.C.G., INC.
351 Hospital Road, Suite 210
Newport Beach, CA 92663
Tel: (949) 548-8800 Fax: 1-855-324-3537

Current Medication List

Patient Name: ____ DOB: _____/_____/_____

Please list **prescription medications first, then any **over-the-counter medications** and **vitamins** that you are taking.

Medication	Dose	Freq	Prescribing Physician
1.			
2.			
3.			
4.			
5.			
6			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

****Are you currently taking any of the following medications? Please circle Yes or No.**

Aspirin	Aleve	Advil	Ginseng	Gingko	Multi-Vitamin	Iron
Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

(More on back)

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351 HOSPITAL ROAD, SUITE 210
NEWPORT BEACH, CA 92663
(949) 548-8800 (voice)
1-855-324-3537 (fax)

DATE: ____/____/____

NAME OF PATIENT: ________________________________
Last First

DATE OF BIRTH: ____/____/____

PLEASE RELEASE MY MEDICAL RECORDS TO:
GLENN D. MADOKORO, M.D., F.A.C.G., INC.
351 Hospital Road, Suite #210
Newport Beach, CA 92663
(**Please note: The office relocated in 2004)
(949) 548-8800 (voice)
1-855-324-3537 (fax)

X____
Signature of Patient

Please list any physicians you are currently seeing (or other gastroenterologists you have seen in the past).

	Name	Specialty	Phone#	Date seen
1.			(___)	
2.			(___)	
3.			(___)	
4.			(___)	

(More on back)

GLENN D. MADOKORO, M.D.,F.A.C.G., INC.
Patient Information Form

Date: ______/______/______

Appointment: ______/______/______

Name: ____
Last First MI

Vital Signs: Ht: ________inches Wt: ________lbs

Age: _____________ Sex: male female

Date of Birth: ______/______/______
Month Day Year

Are you pregnant?: yes no # of Weeks?: ________

Previous Surgeries (If none, write NONE)

Type:	Year:	Hospital:	Physician:

Drug Allergies (If none, write NONE)

______________________________________|______________________________________
______________________________________|______________________________________

Family History

Is patient adopted? Yes No

	Age (if living)	Illnesses	Age at Death	Cause of Death (if known)
Father				
Mother				

	Number of Living	Illness (if known)	Number of Deceased	Age(s) at Death	Cause of Death (if known)
Brother(s)					
Sister(s)					
Son(s)					
Daughter(s)					

Social History

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Do you drink alcohol? YES NO
If yes, how often? _______ drinks per **day** **week** **month** **year**
Preferred drink: ____________________

Use of Tobacco: Never Previously but quit (when: ______________) Current pack/Day: ___________
Total years smoked: _______

Use of Drugs: Never Type/Frequency ____________________

Excessive Exposure at Home/Work to: Fumes Dust Solvents Other: ____________________

Occupation: ____ # of years at job: ________

History of Current Gastrointestinal Symptoms (If none, write NONE)

Principal symptom: ____

History of present illness:

Location: ______________________________
(Where is the pain/problem?)

Quality: ______________________________
(Ex: sharp, aching, burning, etc.)

Severity: ______________________________
(How severe is the pain/problem?)

Duration: ______________________________
(How long have you had the problem? When did it start?)

Timing: ______________________________
(Does the pain/problem occur at a specific time?)

Context: ______________________________
(Ex: begins after meals, a trip, stress, etc.

Patient Signature: X____

(More on back)

GLENN D. MADOKORO, M.D.,F.A.C.G., INC.
Patient Information Form

Patient Medical History

Diabetes	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart Attack	No	Yes
Convulsions	No	Yes
Bleeding Tendency	No	Yes
Blood Thinning Meds	No	Yes

Which ethnic group do you identify with most?

African American
Asian / Pacific Islander
Caucasian / White
Hispanic
Native Hawaiian / Native American / Alaskan Native
Other: ____

Primary Language:
English Spanish Other: ______________________

1. **Has any physician advised you to take antibiotics routinely prior to having your teeth cleaned?** No Yes
2. **Do you take Coumadin (warfarin), Lovenox (enoxaparin), Pradaxa, Plavix, or Eliquis?** No Yes

Review of Systems

General:			**Gastrointestinal:**		
Weight change in last 6 months	No	Yes	Change in bowel movements	No	Yes
amount of change _____ lbs (increase)			Ulcers	No	Yes
amount of change _____ lbs (decrease)			Nausea	No	Yes
Exercise Regularly	No	Yes	Vomiting	No	Yes
Appetite Normal	No	Yes	Diarrhea	No	Yes
Fever	No	Yes	Constipation	No	Yes
Fatigue	No	Yes	Regurgitation	No	Yes
Problem with previous procedure	No	Yes	Colonic Polyp (When? _________)	No	Yes
Sleep Apnea	No	Yes	Abdominal pain	No	Yes
			Heartburn/Reflux	No	Yes
Eyes:			Difficulty Swallowing	No	Yes
Inflammation	No	Yes	Jaundice	No	Yes
Blurred or Double vision	No	Yes	Gallstones	No	Yes
Glaucoma	No	Yes	Hepatitis (Type: ____)	No	Yes
Cataracts	No	Yes	Rectal Bleeding	No	Yes
Ears/Eyes/Mouth/Throat:			**Musculoskeletal:**		
Hearing Loss	No	Yes	Joint pain	No	Yes
Mouth Sores	No	Yes	Back pain	No	Yes
Sore throat or voice change	No	Yes			
Swollen glands in neck	No	Yes	**Integumentary:**		
			Rash	No	Yes
Cardiovascular:			Itching	No	Yes
Chest pain/Angina pectoris	No	Yes			
Arrhythmia	No	Yes	**Neurological:**		
Heart Murmur	No	Yes	Frequent/recurring headache	No	Yes
Heart Attack	No	Yes	Seizures	No	Yes
Palpitations	No	Yes	Numbness	No	Yes
Swelling of feet or ankles	No	Yes	Other: ____________________	No	Yes
Respiratory:			**Psychiatric:**		
Chronic cough	No	Yes	Memory loss/Confusion	No	Yes
Coughing up blood	No	Yes	Nervousness	No	Yes
Shortness of breath	No	Yes	Depression	No	Yes
Wheezing	No	Yes	Eating Disorder	No	Yes
Asthma	No	Yes	Other: ____________________	No	Yes
Pneumonia	No	Yes			
COPD	No	Yes	**Hematological:**		
CPAP machine	No	Yes	Bleeding/Bruising tendency	No	Yes
			Anemia	No	Yes
Genitourinary:			Past transfusion	No	Yes
Frequent Urination	No	Yes	Enlarged glands	No	Yes
Burning or Painful urination	No	Yes	Other: ____________________	No	Yes
Blood in urine	No	Yes			
Decreased force of stream urinating	No	Yes	**Endocrine**		
Kidney stones	No	Yes	Thyroid disease	No	Yes
Incontinence of urine	No	Yes	Diabetes	No	Yes
Prostate tumor	No	Yes	Elevated Glucose	No	Yes
Renal failure	No	Yes			

Name: ________________________________ DOB: _______/_______/_______
Last, First MI

(More on back)

Date: Name:

Date of Birth: / /

ABDOMINAL PAIN/DISCOMFORT QUESTIONNAIRE

1. Do you have abdominal pain? Yes No

2. If yes, how many different kinds of pain do you have? 1 2 3 4 5 More than 5

3. Please describe the worst pain first, then the next, and so forth:

____

____

____

4. Where is the pain located? (check all that apply)

	Right Upper Quadrant		Upper Mid		Left Upper Quadrant
	Right Lower Quadrant		Suprapubic		Left Lower Quadrant
	Right Side		Left Side		All Over

5. Does the pain radiate to any of the following places? (check all that apply. If none apply, mark **NONE** below)

	Right Shoulder		Right Shoulder Blade		The Back		**NONE**
	The Side		The Groin		The Front of the Thigh		

6. When did the pain start? ________ Days Weeks Months Years ago

7. How frequently does the pain occur? ________ times a Day Week Month Year

8. Does the pain occur: (check all that apply)

	Continuously all the time		Episodically		Irregularly
	In a regular pattern		Unpredictably		
	Only if I eat the wrong foods		Mainly with stress		

9. How long does the pain last at a time? _______ Seconds Minutes Hours Days Weeks Months Years

10. What does the pain feel like? (check all that apply)

	ACHING		STABBING		BURNING		THROBBING
	SHARP		DULL		SQUEEZING		CRAMPING
	BLOATING		ELECTRIC		It's not a pain, it's a feeling of having to vomit		

(More on backside)

ABDOMINAL PAIN/DISCOMFORT QUESTIONNAIRE

11. How is the pain affected by each of the following: (check all that apply)

	BETTER	WORSE	UNCHANGED
MEALS			
BOWEL MOVEMENTS			
POSITION			
MOVEMENT			
STRESS			
MEDICATION			

12. Is the pain associated with: (check all that apply. If none apply, mark **NONE** below)

	NAUSEA		FEVER		WEIGHT LOSS		**NONE**
	CONSTIPATION		HEARTBURN		LOSS OF APPETITE		
	REFLUX		FEELING FULL PREMATURELY		DIARRHEA		

13. Have you had any of these tests to evaluate the pain? If so, when and where? (check all that apply. If none apply, mark **NONE** below)

		Date	Location	Result
	CT scan			
	MRI scan			
	Ultrasound			
	Colonoscopy			
	Upper Endoscopy			
	GYN exam			
	PET scan			
	Other			
	NONE			

14. Please circle any medications you have taken for the pain. Did it help? (check all that apply. If none apply, circle **NONE** below)

	Did it help?	
	YES	NO
Aciphex / Dexilant / Nexium / Prilosec / Prevacid / Protonix		
Axid / Pepcid / Tagamet / Zantac		
Tums / Rolaids / Maalox / Mylanta / Gaviscon / Other antacid		
Bentyl / Donnatol / Librax / Levsin / Levsinex / Nulev / Robinul		
Vicodin / Norco / Codeine / Darvon / Ultram		
Demerol / Dilaudid / Fentanyl / Morphine / Actiq		
Antibiotics		
Herbal remedies		
Amitriptyline / Neurontin / Lyrica		
Other:		
NONE		

Date: Name:

Date of Birth: / /

DIARRHEA QUESTIONNAIRE

1. In your usual state, how often do you have a bowel movement?
   _____ times per day, every _____ day(s)

2. Now, how often do you have a bowel movement?
   _____ times per day

3. Do you see blood in the stools? Yes No

4. Have you had a fever? Yes No
   If yes, how high? ________ degrees

5. Is the diarrhea accompanied by abdominal cramping or other pain? Yes No

6. How long ago did the diarrhea begin?
   _____ Days Weeks Months Years ago

7. If the diarrhea occurs intermittently, how often does it occur?
   Every _____ Days Weeks Months Years
   If it occurs unpredictably, how many times does it occur?
   _____ times per Week Month Year

8. Did the diarrhea begin after taking antibiotics? Yes No
   If yes, which one and how long ago? ____________________

9. Did the diarrhea begin after taking a trip? Yes No
   If yes, where to and how long ago? ____________________

10. Did the diarrhea begin after eating any suspicious food? Yes No
    If yes, when and what was it? ____________________

11. Did anyone else get the diarrhea about the same time that you did? Yes No
    If yes, who was it? ____________________ Are they still ill? Yes No

12. Have you had similar episodes of diarrhea in the past? Yes No

13. Have you noticed that the diarrhea is worse after any particular foods? Yes No
    If yes, what food(s)? ____________________

14. Please CIRCLE any of the following medications you have taken to try to alleviate the diarrhea. Did it help? (check all that apply. If none apply, mark **NONE** below)

	Did it help?			Did it help?	
	YES	NO		YES	NO
Imodium			Lotronex		
Pepto-Bismol			Codeine / Paregoric		
Antacids			Herbal remedies		
Kaopectate			A low lactose diet		
Lomotil			A low gluten diet		
Clonidine			**NONE**		

(More on backside)

DIARRHEA QUESTIONNAIRE

15. Have you had any of the following tests to evaluate the diarrhea? If so, when and where? (check all that apply. If none apply, mark **NONE** below)

		Date	Location	Result
	Stool specimens			
	Blood tests			
	Colonoscopy			
	Upper endoscopy			
	Barium enema			
	Small bowel exam			
	Capsule enteroscopy			
	Absorption tests			
	Hormonal assays			
	Other	Please describe:		
	NONE			

16. Have you already been diagnosed with a cause of your diarrhea? Yes No
If yes, what is the diagnosis? ____________________

17. Do you use any of the following milk products? (check all that apply. If none apply, mark **NONE** below)

	Milk		Cream in coffee		Ice cream		**NONE**
	Yogurt		Creamy soups or sauces		Pudding		
	Cheese		Ranch or blue cheese dressing		Custard		

18. Do you use any of the following? (check all that apply. If none apply, mark **NONE** below)

	Alternagel		Gaviscon		Gelusil		**NONE**
	Maalox		Mylanta		Riopan		
	Titralac		**Other** (please specify):				

19. Do you use any of the following? (check all that apply. If none apply, mark **NONE** below)

	Sugarless gum		Sugarless breath mints		**NONE**
	Sugarless candy		Sugarless coffee mints		

20. Did the diarrhea begin after taking any new medication(s) or after a change in the dose of an existing medication?
Yes No
If yes, which medication(s) and how long ago?
NEW medication(s):

MODIFIED medication(s):

21. Do you use any of the following? (check all that apply. If none apply, mark **NONE** below)

	Fish oil supplements		Flax seed oil		Alli
	Calcium supplements		Fat free corn/potato chips		**NONE**