

# PLEASE COMPLETE PRIOR TO VISIT

## HISTORY FORM

NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

CHART NO. \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_

### List Medicine/Food Allergies:

- Eggs       Penicillin       Soy       X-Ray Dye  
 Latex       Propofol/Diprivan       Sulfa       **NONE**

### Past or Present Medical Problems

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Depression         | <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Liver Cancer                 | <input type="checkbox"/> Stroke or TIA      |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Hepatitis A              | <input type="checkbox"/> Liver Disease                | <input type="checkbox"/> Thyroid Disease    |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Diverticulitis     | <input type="checkbox"/> Hepatitis B              | <input type="checkbox"/> Lung Cancer                  | <input type="checkbox"/> Ulcer              |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Diverticulosis     | <input type="checkbox"/> Hepatitis C              | <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Breast Cancer    | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Hepatitis, Other         | <input type="checkbox"/> Pancreatitis                 | <input type="checkbox"/> <b>NONE</b>        |
| <input type="checkbox"/> Celiac Sprue     | <input type="checkbox"/> Esophageal Cancer  | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Prostate Cancer              |   |
| <input type="checkbox"/> Colon Cancer     | <input type="checkbox"/> Gallstones         | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Reflux                       |   |
| <input type="checkbox"/> Crohn's Disease  | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Sexually Transmitted Disease |   |
| <input type="checkbox"/> Defibrillator    | <input type="checkbox"/> Gynecologic Cancer | <input type="checkbox"/> Kidney Stones            | <input type="checkbox"/> Sleep Apnea                  |   |

### Surgeries/Hospitalizations

- Appendix Removal       Heart Surgery/  
Cardiac Stent  
 Colon Resection       Hysterectomy  
 Colostomy       Joint Surgery  
 Gallbladder Surgery       Prostate Surgery  
 Gastric Bypass/  
Obesity Surgery

### Procedures

- Blood Transfusion       ERCP  
 Bravo Capsule       Esophageal Manometry  
 Capsule Endoscopy       Liver Biopsy  
 Colonoscopy       **NONE**  
 Endoscopy

### Social History/Marital Status:

- Single       Separated       Married  
 Divorced       Widowed       Other

### Social History/Recreational Drugs:

- I have never used recreational drugs  
 I have used recreational drugs

### Social History/Alcohol:

- Never  
 Rarely  
 Daily

### Social History/Tobacco:

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

### Social History/Occupation:

Patient Occupation \_\_\_\_\_

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**ARE YOU NOW EXPERIENCING....**

**Gastrointestinal:**

- |                                      |  |   |  |  |
|--------------------------------------|--|---|--|--|
| <input type="radio"/> Abdominal pain | <input type="radio"/> Blood in Stool         | <input type="radio"/> Gas                   | <input type="radio"/> Loss of Appetite         | <input type="radio"/> Trouble Swallowing |
| <input type="radio"/> Belching       | <input type="radio"/> Change in Bowel Habits | <input type="radio"/> Heartburn/GERD        | <input type="radio"/> Milk Intolerance         | <input type="radio"/> Vomiting           |
| <input type="radio"/> Black Stool    | <input type="radio"/> Constipation           | <input type="radio"/> Incontinence to Stool | <input type="radio"/> Nausea                   | <input type="radio"/> <b>NONE</b>        |
| <input type="radio"/> Bloating       | <input type="radio"/> Diarrhea               | <input type="radio"/> Jaundice              | <input type="radio"/> Pain with Bowel Movement |  |

**Genitourinary:**

- Blood in urine
- Change in urinary frequency
- Difficulty with Urination
- NONE**

**Skin:**

- Itching  **NONE**
- Rashes

**Cardiovascular:**

- Angina/Chest Pressure  **NONE**
- Irregular Heart Beat

**Respiratory:**

- Cough  **NONE**
- Shortness of Breath

**Neurological:**

- Headaches
- Seizures
- NONE**

**Endocrine:**

- Excessive thirst or Urination
- Hair Change
- NONE**

**Constitutional:**

- Fever
- Weight Loss
- NONE**

**Psychiatric:**

- Anxiety
- Depression
- NONE**

**Eyes:**

- Change in Vision
- Eye Pain
- NONE**

**Hematologic:**

- Enlarged Glands  **NONE**
- Prolonged Bleeding

**Ears, Nose and Throat:**

- Hoarseness
- Mouth Sores
- NONE**

**Musculoskeletal:**

- Joint Pain  **NONE**
- Swollen Joints

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**FAMILY HISTORY**

	Father	Mother	Brother(s)	Sister(s)	Grandparent
Colon Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
age at diagnosis	_____	_____	_____	_____	_____
Colon Polyps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crohn's Disease/ Ulcerative Colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Esophageal Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gastric Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pancreatic Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	_____	_____	_____	_____	_____

**Please list any medications (prescriptions, over-the-counter, herbals, vitamins, etc.) you are currently taking. Include the amount and how often:**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Immunizations (such as flu shots, Hepatitis A, Hepatitis B):**

_____	_____
_____	_____

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**GASTROINTESTINAL ASSOCIATES, INC.  
PATIENT REGISTRATION**

Welcome to our practice. Please complete all sections of this registration form. Thank you.

**Patient Information**

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex: M F Marital Status: Single Married Other Student: FT PT

Employed By \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Home Phone# \_\_\_\_\_ WorkPhone# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_  
(Other than numbers listed above)

**Referral Information**

Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_ Telephone# \_\_\_\_\_

**Insurance Company Information**

Patient's Relationship to Insured Party (Circle One): Self Child Wife Husband Other

Primary Insurance Co. \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE THIS INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION, HEALTH CARE FINANCING ADMINISTRATION, MY INSURANCE COMPANY OR ITS INTERMEDIARIES OR CARRIERS, OR TO THIS PHYSICIAN'S OFFICE OR TO MY ATTORNEY OR OTHER DOCTOR'S OFFICE.

I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE, AND ANY OTHER HEALTH PLAN TO GASTROINTESTINAL ASSOCIATES, INC. I ALSO PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
(2/09)