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**Gastroenterology & Hepatology**  
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### Patient Information

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Legal Sex: F M

Address: \_\_\_\_\_  
                                     Street/Apt                                    City                                    State                                    Zip Code

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Soc. Sec #: \_\_\_\_\_ Email: \_\_\_\_\_

Race: Asian Black/African American White/Caucasian Native American Other: \_\_\_\_\_

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino

Primary Care Doctor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

### Insurance Information

Primary Insurance	Secondary Insurance
Name of Insurance:	Name of Insurance:
Insured's Name:	Insured's Name:
Insured's Legal Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Insured's Legal Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Insured's Date of Birth:	Insured's Date of Birth:
Relationship with Insured's: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Relationship with Insured's: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent
Patient ID #:	Patient ID #:
Group #:	Group #:

### Permission to Disclose Health Information

Do we have permission to:

Leave a message on your answering machine at home or cell? Yes No

May we email results to your personal email address? Yes No

May we discuss your medical condition or results with any other member of your household? Yes No

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



### Past or Present Medical Illnesses (Mark all that apply):

<input type="checkbox"/> None	<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteopenia
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Hernia: <input type="checkbox"/> Inguinal <input type="checkbox"/> Umbilical <input type="checkbox"/> Hiatal	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Arthritis: <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> COPD	<input type="checkbox"/> Fatty Liver	<input type="checkbox"/> Irritable Bowel: <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer: Type: _____	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Cirrhosis of Liver	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Stroke
<input type="checkbox"/> Colitis: <input type="checkbox"/> Ischemic <input type="checkbox"/> Ulcerative	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Thyroid Disease: <input type="checkbox"/> Low <input type="checkbox"/> High
<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Small Bowel <input type="checkbox"/> Large Bowel	<input type="checkbox"/> Heart Disease: <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Migraines	<input type="checkbox"/> Ulcer: <input type="checkbox"/> Duodenal <input type="checkbox"/> Stomach
Other: _____			

### Previous Surgeries/ Procedures (Mark all that apply):

<input type="checkbox"/> None	<input type="checkbox"/> Colonoscopy Year: _____	<input type="checkbox"/> Heart Valve Replacement	<input type="checkbox"/> Prostate <input type="checkbox"/> Biopsy <input type="checkbox"/> Removal
<input type="checkbox"/> Appendix	<input type="checkbox"/> EGD/Upper Endoscopy Year: _____	<input type="checkbox"/> Joint: _____ <input type="checkbox"/> Surgery <input type="checkbox"/> Replacement	<input type="checkbox"/> Stomach
<input type="checkbox"/> Back/Spine	Sigmoidoscopy Year: _____	<input type="checkbox"/> Kidney Removal <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Thyroid <input type="checkbox"/> Biopsy <input type="checkbox"/> Removal
<input type="checkbox"/> Blood Transfusion When: _____	<input type="checkbox"/> Gallbladder Removal	<input type="checkbox"/> Liver Biopsy Year: _____	<input type="checkbox"/> Tonsils
<input type="checkbox"/> Breast ( <input type="checkbox"/> Right <input type="checkbox"/> Left) <input type="checkbox"/> Biopsy <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Cosmetic <input type="checkbox"/> Mastectomy	<input type="checkbox"/> Heart Bypass <input type="checkbox"/> Heart Stent	<input type="checkbox"/> Obesity Surgery: <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Gastric Sleeve <input type="checkbox"/> Tummy Tuck	<input type="checkbox"/> Transplant Surgery Type: _____
<input type="checkbox"/> C-Section	<input type="checkbox"/> Hemorrhoid Surgery	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Colon Resection	<input type="checkbox"/> Hernia Repair <input type="checkbox"/> Hiatal <input type="checkbox"/> Inguinal <input type="checkbox"/> Umbilical	<input type="checkbox"/> Hysterectomy <input type="checkbox"/> Partial <input type="checkbox"/> Total	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Defibrillator	Other: _____		

### Review of Systems (Mark all that apply):

General	<input type="checkbox"/> Change In Appetite <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss
Eyes	<input type="checkbox"/> Discharge <input type="checkbox"/> Pain <input type="checkbox"/> Redness
ENT	<input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Decreased Smell <input type="checkbox"/> Ear Pain <input type="checkbox"/> Sore Throat <input type="checkbox"/> Nosebleed
Endocrine	<input type="checkbox"/> Excessive Sweating <input type="checkbox"/> Excessive Thirst
Respiratory	<input type="checkbox"/> Cough <input type="checkbox"/> Shortness Of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing Up Blood
Heart	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness Of Breath On Exertion
Gastrointestinal	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Blood In Stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood
Genitourinary	<input type="checkbox"/> Blood In Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Heavy Menstrual Periods
Musculoskeletal	<input type="checkbox"/> Back Problems <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Joint Pain <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Muscle Aches
Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Abnormal Moles
Neurologic	<input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss Of Strength <input type="checkbox"/> Memory Loss <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis
Psychiatric	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Stressors <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicidal Thoughts