GASTROENTEROLOGY REGISTRATION INFORMATION

PATIENT FULL NAME:_____ **MALE (____) FEMALE (____)**

AGE:_____ **BIRTH DATE:**_____ **MARRIED(____) SINGLE(____) WIDOWED(____)**

RACE:_____ **ETHNICITY:**_____ **PRIMARY LANGUAGE:**_____

HOME PHONE:_____ **CELL PHONE:**_____

SOCIAL SECURITY #:_____-_____-_____ **DRIVERS LICENSE #:**_____

EMAIL ADDRESS:_____

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

PRIMARY INSURANCE CO:_____

SUBSCRIBERS NAME: _____ **DATE OF BIRTH:**_____

SUBSCRIBER NUMBER:_____ **GROUP NUMBER:**_____

SECONDARY INSURANCE CO:_____

SUBSCRIBERS NAME: _____ **DATE OF BIRTH:**_____

SUBSCRIBER NUMBER: _____ **GROUP NUMBER:**_____

EMPLOYED BY:_____**OCCUPATION:**_____

MESSAGE/EMERGENCY CONTACT:_____ **PHONE:** _____

PREFERRED PHARMACY:_____

PHARMACY ADDRESS:_____ **PHONE:**_____

FAMILY DOCTOR:_____**REFERRED BY:**_____

CLINICAL HISTORY FORM

To provide optimum care, we need to know your medical history, surgical history, medications and allergies.

PATIENT'S NAME:_____ APPT DATE:_____

A. Check the Appropriate Box if You've Ever Had **ANY** of the Following:

Y	N		Y	N	
( )	( )	Heart Attack / Myocardial Infarction	( )	( )	Stomach or Duodenal Ulcers
( )	( )	Heart Valve Replacement	( )	( )	Chronic Heartburn / GERD
( )	( )	Pacemaker or Defibrillator Placement	( )	( )	Liver Cirrhosis / Liver Failure / Jaundice
( )	( )	Atrial Fibrillation	( )	( )	Asthma (other than childhood)
( )	( )	Congestive Heart Failure	( )	( )	Emphysema / COPD
( )	( )	High Blood Pressure / Hypertension	( )	( )	Depression / nervous breakdown
( )	( )	Organ Transplant	( )	( )	Cancer
		(Type:_____)			(Type:_____)
( )	( )	Artificial Joints / Joint replacement	( )	( )	Gout
( )	( )	Acquired Immunodeficiency Syndrome (AIDS)	( )	( )	High Cholesterol / Triglycerides
( )	( )	Kidney Disease / Renal Failure	( )	( )	Anemia
( )	( )	Diabetes	( )	( )	Thyroid or other endocrine problems
( )	( )	Severe Glaucoma or Legal Blindness	( )	( )	Tuberculosis
( )	( )	Stroke / CVA	( )	( )	Other: _____
( )	( )	Seizure / Epilepsy	( )	( )	Other: _____

B. Please List All Major Surgeries:

1)_____ Date:_____

2)_____ Date:_____

3)_____ Date:_____

4)_____ Date:_____

5)_____ Date:_____

6)_____ Date:_____

C. Please List ALL Medical Allergies:

1)_____ Reaction:_____

2)_____ Reaction:_____

3)_____ Reaction:_____

4)_____ Reaction:_____

5)_____ Reaction:_____

PATIENT'S NAME:_____ APPT DATE:_____

D. Please List Your Current Medications, Dose, and Schedule:

Medication	Dose	Schedule

E. Personal / Social Information:

Y	N	
( )	( )	Do you currently Smoke / Chew Tobacco? What_____ How much?_____
( )	( )	Do you drink alcohol regularly? What?_____ How often?_____
( )	( )	Do you currently use recreational drugs (marijuana, cocaine, heroin, etc.)?
( )	( )	WOMEN: Could you be, or are you **pregnant**? If so, PLEASE tell us.

F. Immediate Family History (only mother, father, siblings, children):

Please list any major gastrointestinal illnesses in your immediate family (colon cancer, Crohn's disease, ulcerative colitis, peptic ulcer disease, liver disease, celiac sprue, etc.)

_____

_____

_____

PATIENT'S NAME:_____ APPT DATE:_____

G. System Review: Do you have, or recently had, any of the following?

Yes	No	GENERAL
( )	( )	Feel tired, worn out
( )	( )	Having chills, fevers, sweats
( )	( )	Lost or gained weight (unexplained)
		How much: Loss_____ Gain_____

Yes	No	SKIN
( )	( )	Skin rashes or itching
( )	( )	Changes in skin color / jaundice
( )	( )	Excessive / unusual hair loss

Yes	No	EYES
( )	( )	Pain in your eyes
( )	( )	Blurred vision
( )	( )	Poor night vision
( )	( )	Glaucoma

Yes	No	EARS/NOSE/THROAT
( )	( )	Problems hearing / wear hearing aids
( )	( )	Lump in throat
( )	( )	Post nasal drip / abnormal drainage
( )	( )	Tinnitus / ringing in ears
( )	( )	Sores in mouth or on tongue

Yes	No	RESPIRATORY
( )	( )	Persistent / recurring cough
( )	( )	Shortness of breath at rest
( )	( )	Shortness of breath with mild exertion
( )	( )	Coughing up blood

Yes	No	CARDIOVASCULAR
( )	( )	Chest pains or pressure with exertion
( )	( )	Swelling of feet or ankles
( )	( )	Inability to lay flat due to shortness of breath
( )	( )	Waking at night short of breath
( )	( )	Irregular or rapid heart beat

Yes	No	GENITOURINARY
( )	( )	Burning or painful urination
( )	( )	Frequent urination
( )	( )	Passing blood in urine

Yes	No	WOMEN ONLY
( )	( )	Abnormal or missed menstrual periods
( )	( )	Lumps in breasts
( )	( )	Abnormal nipple discharge
( )	( )	Deformity of breast or nipple

Yes	No	GASTROINTESTINAL
( )	( )	Difficult or painful swallowing
( )	( )	Passing red blood in stool
( )	( )	Black tarry stools
( )	( )	Persistent or recurrent abdominal pain
( )	( )	Diarrhea
( )	( )	Constipation
( )	( )	Persistent change in usual bowel pattern
( )	( )	Nausea / Vomiting
( )	( )	Loss of appetite or will to eat
( )	( )	Chronic indigestion
( )	( )	Abdominal bloating
( )	( )	Jaundice or yellow skin/eyes

Yes	No	HEMATOLOGIC / LYMPHATIC
( )	( )	Swollen glands?
( )	( )	Easy bruising or excessive bleeding

Yes	No	NEUROLOGIC
( )	( )	Frequent headaches / migraines
( )	( )	Memory loss / forgetfulness
( )	( )	Focal weakness in arms or legs
( )	( )	Numbness or tingling
( )	( )	Loss of balance or coordination
( )	( )	Dizziness or fainting spells

Yes	No	PSYCHIATRIC
( )	( )	Feeling depressed / down mood
( )	( )	Feeling excessive anxiety
( )	( )	Thoughts of hurting yourself or others
( )	( )	Insomnia / inability to sleep

Yes	No	ENDOCRINE
( )	( )	Feeling too hot or cold
( )	( )	Diffuse weakness

Yes	No	MUSCULOSKELETAL
( )	( )	Joint stiffness / pain
( )	( )	Joint swelling
( )	( )	Back pain
( )	( )	Painful muscles

Yes	No	MEN ONLY
( )	( )	Erectile problems
( )	( )	Poor / difficult urinary stream

Other:

_____ _____

Signature Date