MRN	

GASTROINTESTINAL DISEASES, INC.

PATIENT INFORMATION FORM

PATIENT INFORMATION *Must provide ID at each appointment*		
Last Name:	First Name:	M.I.
DOB:	SSN:	
Home #:	Cell #:	Work #:
Street Address:		Apt #/Suite #:
City:	State:	Zip:
Email Address:		
Current occupation:	Currently working: ☐ Y ☐ N If yes, hours per week:	

EMERGENCY CONTACT		
Last Name:	First Name:	Phone:
Relationship to patient:		

INSURANCE INFORMATION *Must provide physical insurance card at each appointment*		
Full name as it appears on **Primary** Insurance Card:		
Insurance Name:	Member Id:	Group #:
Medical Claims Billing Address:		
Full name as it appears on **Secondary** Insurance Card: *if different from primary*		
Insurance Name:	Member Id:	Group #:
Medical claims billing address:		
Any additional Insurance Information: *add here, if insurance is obtained through spouse/partner, please provide their full name, ssn and employer*		

PLEASE MAKE SURE TO FILL OUT BOTH SIDES IN THE ENTIRETY

PATIENT INFORMATION		
Last Name:	First Name:	DOB:

PHYSICIAN INFORMATION	
Referring Physician:	Phone #:
PCP:	Phone #:

PHARMACY INFORMATION
Preferred Pharmacy Location:

HIPAA & PHI AUTHORIZATION FORM
The authorization for release of PERSONAL HEALTH INFORMATION is valid for ***1 year*** from date of signature on this form. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). Gastrointestinal Diseases Inc. may disclose your information (PHI), for treatment, payment, and health care operations purposes with your consent.
Signature: Date:
EXLUDE the following information from records released:

AUTHORIZATION TO DISCLOSE PHI *valid for* ***1 year***
Name of family member or personal representative:

PLEASE MAKE SURE TO FILL OUT BOTH SIDES IN THE ENTIRETY

Signature:	Date:

GASTROINTESTINAL DISEASES, INC.

Date	
MRN	
MA initials	

PATIENT HISTORY FORM

PATIENT INFORMATION

Last Name:	First Name:	DOB:

RACE *Select one or more*

	White		Black/African American		Asian		American Indian or Alaska Native		Native Hawaiian or Other Pacific Islander
	Other Race		Unknown		Patient declines to specify		Prohibited by state law		

Ethnicity

	Hispanic or Latino		Not Hispanic or Latino		Patient declines to specify		Prohibited by law		Unknown

Gender *At birth*

	Male		Female		Other		Unknown

Marital Status

	Single		Married		Divorced		Other:

What are you being seen for today?

Describe your current symptom(s):

Please list other providers you have seen for these symptom(s):

Do you see a Cardiologist: ☐ Y ☐ N If yes, please list the provider(s) name:

Have you been hospitalized in the last 6 months: ☐ Y ☐ N Location(s):

Date(s): Reason(s):

Have you received a Colonoscopy/EGD: ☐ Y ☐ N If yes, what year(s): Location(s):

SURGICAL HISTORY: Have you ever had any of the following surgeries? ☑ *Check if yes and include date(s) and location(s)*

	Adrenal Gland		Colon Resection		Kidney
	Appendectomy		Coronary Artery Bypass Graft		Neck
	Bariatric		Esophagus		Prostate
	Bladder		Gastric Bypass		Small Intestine
	Breast		Heart Stent(s)		Spinal
	Cesarean Section		Hemorrhoid		Stomach
	Cholecystectomy		Hernia		Thyroid
	Colonoscopy		Hysterectomy		

Please list any other surgeries not listed above:

ALLERGIES

	Patient has no known allergies				Patient has no known drug allergies		
	Latex		Shellfish		Seafood		Eggs
	Tylenol		Flagyl		Penicillin		Erythromycin
	Cipro		Codeine Sulfate		Iodine and Iodide Containing Products		Analgesic Aspirin or Caffeine
	Sulfa		Demerol		Nickel		Other:

FAMILY HISTORY

	Living	Age	Medical Issues/Diagnoses	Deceased	Age At Death
Mother					
Father					
Sister					
Brother					
Child					
Other					

SIGNIFICANT GASTRO CONDITIONS: *Colon cancer, Colon polyps, Crohn's disease, Ulcerative colitis, Esophageal cancer, Gastric cancer, Liver*

CURRENT MEDICATIONS: *Must include non-prescription, vitamins and supplements*

Name:	Dose: *Including strength & amount per day*
	*If you need more space, please use the back page, or attach a printed list

VACCINATIONS

	Flu [Date:]		Pneumonia [Date:]		Shingles [Date:]		Covid [Date:]

MEDICAL HISTORY: Past and Present *Check if yes*

	Diabetes		Heart Murmur		Crohn's Disease
	High Blood Pressure		Pneumonia		Colitis
	High Cholesterol		Pulmonary Embolism		Anemia
	Hypothyroidism		Asthma		Yellow Jaundice
	Goiter		Emphysema		Hepatitis
	Cancer (type):		Stroke		Stomach/ Peptic Ulcer
	Leukemia		Epilepsy (seizures)		Rheumatic Fever
	Psoriasis		Cataracts		Tuberculosis
	Angina		Kidney Disease		HIV/ AIDS
	Heart Problems		Kidney Stones		

Other medical conditions (please list):

PERSONAL HISTORY/SOCIAL

Do you use consume caffeinated products? *Coffee, soda, energy drinks, caffeine shots, pre-work out* ☐ Y ☐ N

If yes, how much and how often?

Do you use tobacco products? *Cigarettes, cigars, chewing tobacco/dipping, vaping* ☐ *Y* ☐ *N*

If yes, how much and how often?

Do you consume alcohol products? *Beer, wine, liquor* ☐ *Y* ☐ *N*

If yes, how much and how often? Are you a recovering alcoholic? ☐ Y ☐ N When did you quit?

Do you use illicit drugs? ☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Opioids ☐ Other:

If yes, how much and how often?

SYMPTOM REVIEW					
GENERAL		*NERVOUS SYSTEM*		*PSHYCHIATRIC*	
	Recent weight gain:		Headaches		Depression
	Recent weight loss		Dizziness		Excessive worries
	Fatigue		Fainting or loss of consciousness		Difficulty falling asleep
	Weakness		Numbness or tingling		Difficulty staying asleep
	Fever		Memory loss		Difficulties with sexual arousal
	Night sweats				Poor appetite
		STOMACH AND INTESTINES			Food cravings
MUSCLE/JOINT/BONES			Nausea		Frequent crying
	Numbness		Heartburn		Sensitivity
	Joint pain		Stomach pain		Thought of suicide/attempts
	Muscle weakness		Vomiting		Stress
	Joint swelling, where?		Yellow jaundice		Irritability
			Increasing constipation		Poor concentration
EARS			Persistent diarrhea		Racing thoughts
	Ringing in ears		Blood in stools		Hallucinations
	Loss of hearing		Black stools		Rapid speech
					Guilty thoughts
EYES		*SKIN*			Paranoia
	Pain		Redness		Mood swings
	Redness		Rash		Anxiety
	Loss of vision		Nodules/bumps		Risky behavior
	Double or blurred vision		Hair loss		
	Dryness		Color changes or hands or feet	*OTHER*:	
THROAT		*BLOOD*			
	Frequent sore throats		Anemia		
	Hoarseness		Clots		
	Difficulty swallowing			*WOMENS REPRODUCTIVE HISTORY*	
	Pain in jaw	*KIDNEY/URINE/BLADDER*		Do you still have your period?	
			Frequent or painful urination	# Pregnancies:	
HEART AND LUNGS			Blood in urine	# Miscarriages:	
	Chest pain			# Abortions:	
	Palpitations	*WOMEN ONLY*		Have you reached menopause? At what age?	
	Shortness of breath		Abnormal Pap smear	Do you have regular periods?	
	Fainting		Irregular periods	Any chance you might be pregnant?	
	Swollen legs or feet		Bleeding between periods	Are you actively trying to get pregnant?	
	Cough		PMS	Do you use any form of birth control?	

PLEASE MAKE SURE TO FILL OUT THE ENTIRETY

Signature:	Date: