PATIENT INFORMATION

Last Name: Prefix:	Primary Physician:
First Name: Middle Initial:	Referring Physician:
Address: Apt:	Date of Birth:
City: State: Zip Code:	Marital Status: (Circle One) Single/ Married/ Divorced/ Widowed
Home Phone: Cell Phone:	Social Security #:
Work Phone: Ext: Preferred Number: (circle one) Home / Cell	Employer:

EMERGENCY CONTACT INFORMATION

Name :	Relationship:
Street Address Apt:	Home Phone:
City State Zip Code:	Cell Phone:
May we speak to your Emergency Contact regarding test results : (Circle One) Yes / No	Work Phone:

PRIMARY INSURANCE INFORMATION

Name of **Primary** Health Insurance Plan:

Subscriber's Name:	Subscriber's ID#	Subscriber's DOB:
Relationship to Patient: (Circle one) Self Spouse Partner Parent Guardian Other		Copay Amount: $

SECONDARY INSURANCE INFORMATION

Name of **Secondary** Health Insurance Plan:

Subscriber's Name:	Subscriber's ID#	Subscriber's DOB:
Relationship to Patient: (Circle one) Self Spouse Partner Parent Guardian Other		Copay Amount: $

GENERAL INFORMATION:

E-mail Address:	May we leave you voicemails: (Circle One) Yes / No

Volunteer information for government reporting requirements: (Please Circle One):

Race: White Hispanic African American American Indian Other Race _____

Ethnicity: Hispanic or Latin Not Hispanic or Latin Refused to Report

Language: English Spanish Russian Other _____

PHARMACY INFORMATION

Local Pharmacy/Address/Phone Number:	Living Will: (Circle One) Yes / No
Mail Order Pharmacy:	Consent to patients Rx History: (Circle One) Yes / No

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. It is my responsibility to pay any copays, deductibles or any other balance not paid for by my insurance. A No-Show Fee may apply to missed appointments. If a referral is needed for insurance, it is my responsibility to get that referral from my PCP.
2. I authorize the release of all medical information to process claims for medical care received. I assign all medical benefits, including major medical benefits to which I am entitled to Great Lakes Gastroenterology, this assignment is to be considered as valid as the original.
3. I am aware of the Great Lakes Gastroenterology (HIPAA) Privacy Act and I understand I have the right to have a copy furnished to me upon request.
4. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment
5. PATIENT RIGHTS AND RESPONSIBILITIES: A copy of your rights and responsibilities are posted and a copy is available upon request.

SIGNATURE

Patient Signature:	Date:

REVIEW OF SYSTEMS

Patient Name: _____ **Date of Birth:**_____

Reason for today's visit: _____

Current Medications – List **ALL** medications, **prescription**, **supplements**, and **over the counter** medications

Medication Name:	Dose and Frequency:	Reason for taking:

Medical History:

Anemia	No	Yes	High Cholesterol	No	Yes
Ascites	No	Yes	HIV	No	Yes
Asthma	No	Yes	Irritable Bowel Syndrome	No	Yes
Cancer Type: _____	No	Yes	Kidney Stones	No	Yes
Colitis	No	Yes	Liver Disease	No	Yes
Colon Polyps	No	Yes	Low Blood Pressure	No	Yes
Crohn Disease	No	Yes	Migraine Headaches	No	Yes
Depression	No	Yes	Pancreatitis	No	Yes
Diabetes	No	Yes	Peripheral Vascular Disease	No	Yes
Diverticulosis	No	Yes	Seizures	No	Yes
Emphysema or COPD	No	Yes	Sleep Apnea	No	Yes
Endometriosis	No	Yes	Stomach Ulcer	No	Yes
Gallstones	No	Yes	Stroke/TIA	No	Yes
Hepatitis Type:_____	No	Yes	Thyroid Disease	No	Yes
High Blood Pressure	No	Yes	Other: _____	No	Yes

Allergies, sensitivities, reactions: **☐ Check If None**

Past Surgical History: Year:

Abdominal Surgery Type:_____	No	Yes
Appendectomy	No	Yes
Cancer Surgery Type:_____	No	Yes
Cosmetic Surgery Type:_____	No	Yes
Colon Surgery Type:_____	No	Yes
Gallbladder removal	No	Yes
Hemorrhoid Removal	No	Yes
Hernia: Type:_____ Any Mesh _____	No	Yes
Hysterectomy (TAH)	No	Yes
Hip Surgery Metal or Plastic	No	Yes
Knee Surgery Metal or Plastic	No	Yes
Shoulder Surgery Metal or Plastic	No	Yes
Any other metal in body _____	No	Yes
Laparoscopy	No	Yes
Tonsillectomy	No	Yes
Other _____	No	Yes

Anesthesia Questionnaire: Year:

Any past problems with anesthesia?	No	Yes
Atrial fibrillation	No	Yes
CABG (Coronary artery bypass grafting)	No	Yes
Congestive / Chronic heart failure	No	Yes
Defibrillator - Date last checked:_____	No	Yes
Have you been told you are a difficult intubation?	No	Yes
Heart Attack	No	Yes
Heart Stents	No	Yes
Heart valve replacement	No	Yes
Kidney failure / Dialysis	No	Yes
Organ transplant	No	Yes
Oxygen therapy	No	Yes
Pacemaker - Date last checked:_____	No	Yes
Shortness of breath with (1) flight of stairs	No	Yes

Cardiologist (Heart) Phy: _____

Pulmonologist (Lung) Phy:_____

Nephrologist (Kidney) Phy:_____

(Recent) Hospitalizations (non-surgical): ☐ Check If None

Family Medical History – If yes, please list the relation and age: ☐ Check If None

Colon Cancer	No	Yes	_____
Colon Polyps	No	Yes	_____
Inflammatory Bowel Disease	No	Yes	_____
Cancer of:			
Endometrial	No	Yes	_____
Esophagus	No	Yes	_____
Kidney	No	Yes	_____
Ovarian	No	Yes	_____
Pancreas	No	Yes	_____
Small Bowel	No	Yes	_____
Stomach	No	Yes	_____

Social History:

Marital Status: ( ) - Single ( ) - Married ( ) - Separated ( ) - Divorced ( ) - Widowed
Children: ( ) - No ( ) - Yes How Many?_____
Use of Alcohol: ( ) - None ( ) - Yes How Much/Often?_____
Recreational Drug Use: ( ) - No ( ) - Yes - If Yes, Drug Type:_____
Use of Nicotine/Tobacco: ( ) - Never ( ) - Quit ( ) - Yes ( ) - Smoking ( ) - Chewing ( ) - E-Cigarettes - How Much?_____
If **Yes** to Quit, How long ago? _____

Are you having any of the following symptoms:

Gastrointestinal			**HEENT**			**Neurological**		
Nausea	No	Yes	Sore throat	No	Yes	Seizures	No	Yes
Vomiting	No	Yes	Hoarseness	No	Yes	Headaches	No	Yes
Heartburn	No	Yes						
Food sticking in throat	No	Yes	**Cardiovascular**			**Dermatology**		
Painful swallowing	No	Yes	Abnormal heart rhythm	No	Yes	Rash	No	Yes
Vomiting blood	No	Yes	Chest pain	No	Yes			
Black stool	No	Yes	Palpitations	No	Yes	**Musculoskeletal**		
Red blood in stool	No	Yes				Joint Pain	No	Yes
Abdominal pain	No	Yes	**Respiratory**			Arthritis	No	Yes
Constipation	No	Yes	Cough	No	Yes			
Diarrhea	No	Yes	Shortness of breath on exertion	No	Yes	**Psychiatric**		
Loss of appetite	No	Yes	Shortness of breath at rest	No	Yes	Dementia	No	Yes
Early satiety	No	Yes	Wheezing	No	Yes	Depression	No	Yes
Bloating	No	Yes				Anxiety	No	Yes
Hemorrhoids	No	Yes						
			Genitourinary					
Constitutional			Frequent urination	No	Yes	Height:_____		
Recent weight gain	No	Yes	Kidney failure/dialysis	No	Yes	Weight:_____		
# of pounds____			Painful urination	No	Yes			
Recent weight loss	No	Yes						
# of pounds ____								
Fever	No	Yes						
Fatigue	No	Yes						

GI History:

When: **Physician Who Performed:**

Have you had a previous colonoscopy? No Yes
Have you had a previous EGD? No Yes _____

Authorization and Release:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status. I authorize the healthcare staff to perform necessary services I may need and release information to others if necessary for my care.

Signature of Patient: **Date:**