Gastroenterology and
Internal Medicine Specialists, S.C.

A division of

Patient Information

Last Name First Name Middle Initial

Address

City State Zip Code

☐Home Phone *(Please check off preferred phone number)* ☐Work Phone ☐Cell Phone

E-mail Address Marital Status

Social Security Number: _____ - _____ - _______ Date of Birth: _____ / _____ / _______ Sex: ☐ Male ☐ Female

Primary Care Physician: __________________________ Referring Physician (if different from PCP): _________________________________

Primary Insurance

Primary Insurance Provider:______________________________

Insurance Identification Number:_________________________

Group/Policy Number:__________________________________

Primary holder name:__________________________________

Primary holder DOB: ____________________________

Relationship to Patient:________________________________

Primary holder SSN:_______-______-_______

Is policy through employer? Yes ☐ No ☐

If yes: Employer (even if retired):______________________________

If no explain:____

____

Secondary Insurance (If applies)

Secondary Insurance Provider:________________________________

Identification Number:_____________________________________

Group/Policy Number:_____________________________________

Secondary holder name:____________________________________

Secondary holder DOB:________________________________

Relationship to Patient:____________________________________

Secondary holder SSN:_______-______-________

Is policy through employer: ☐ Yes ☐ No

If yes: Employer (even if retired):____________________________

If no explain: ____

____

☐ Same as above

Patient's Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: _____________________________

Name of Employer (Company Name) Occupation

Phone Number: (_____) _____ - __________

X Signature____ **Date**_________________________________

Advance Directives

Date Reviewed: _______________ ☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ HC Proxy

Immunizations

Adult Immunizations – Please check and indicate the immunization date to all that apply. List actual or approx. dates.

☐ Hepatitis A (HAV) ___________ ___________ ___________

☐ Hepatitis B (HBV) ___________ ___________ ___________

☐ Influenza (LAIV) ___________

☐ Other: _________________________________ ___________

Health Maintenance			**Date of last**
Colonoscopy	☐ Yes	☐ No	_____________
DEXA Scan	☐ Yes	☐ No	_____________
EGD	☐ Yes	☐ No	_____________
Flexible Sigmoidoscopy	☐ Yes	☐ No	_____________
History and Physical	☐ Yes	☐ No	_____________
Lipid Panel	☐ Yes	☐ No	_____________

Disease Management			**Date of last**
Abdominal Ultrasound	☐ Yes	☐ No	_____________
Cardiac Stress Test	☐ Yes	☐ No	_____________
Chest X-Ray	☐ Yes	☐ No	_____________
Echocardiogram	☐ Yes	☐ No	_____________
EKG	☐ Yes	☐ No	_____________
Pulmonary Function Tests	☐ Yes	☐ No	_____________

Medications

List all medications you take, prescription and nonprescription, and their dosage: ☐ No medications

Medication	**Dose- MUST fill out completely**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Please use another piece of paper to list any additional medications taken. ***If possible, please bring your medication bottles with you!***

Pharmacy Information: **Preferred Local Pharmacy:____________________ Location/City:_________________________________**

Mail Order Pharmacy (if used):______________________________

X **Consent: I authorize Gastroenterology & Internal Medicine Specialists, SC to obtain my prescription history electronically: ☐YES ☐NO**

Allergies

Please list any allergies to medications/medical supplies (i.e. Latex) or foods:

Medication	**Reaction**	**Food**	**Reaction**

Social History

Do you use tobacco? ☐ Yes ☐ No ☐ Former Type of tobacco used? _______________/_________________

Packs per day? ____ Years smoked? ___________________ Year Quit? _______________

Other Tobacco units per day (cans, cigars, etc)? ____

Units per day? _______________________ Years used? _________________ Year Quit? _______________

Do you drink caffeine? ☐ Yes ☐ No Type? _____________________ Amount Daily? ___________

Do you drink alcohol? ☐ Yes ☐ No ☐ Former Year Quit? ______________

Type? ___________________________________ How much per week? ____

Amount? ________________________________ Last Drink? ____

Family History

Please check if any family member has had any of the following conditions and indicate if it was the cause of death, write COD.
Please specify if the grandparents are maternal or paternal using an M or P. ☐ **Adopted**

	Mother	**Father**	**Sibling(s)**	**Grandparents**	**Children**
Alcoholism					
Alzheimer's disease					
Asthma					
Blood disorder					
Cancer- Type: ______________________					
Colon cancer					
Crohn's					
Depression					
Diabetes					
Diverticular disease					
Gallbladder disease					
Hearing deficiency					
Heart disease					
Hyperlipidemia					
Hypertension					
Irritable bowel syndrome					
Kidney disease					
Liver disease					
Mental illness					
Migraines					
Obesity					
Osteoporosis					
Peripheral Vascular Disease					
Seizures/epilepsy					
Stroke (CVA)					
Other:__________________________					
Other:__________________________					

For office use only

____ Meds ____ Allergies _____ History ____ Family hx

Name:____ **Date of birth:**______________________

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Ascites
- ☐ Asthma
- ☐ Barrett's esophagus
- ☐ Blood clots
- ☐ Cancer
  Type:________________
- ☐ Celiac disease
- ☐ Chronic blood thinner use
- ☐ Chronic bronchitis
- ☐ Chronic constipation
- ☐ Chronic diarrhea
- ☐ Chronic neck pain
- ☐ Chronic sinusitis
- ☐ Circulatory disease
- ☐ Colitis
- ☐ Congestive heart failure
- ☐ Constipation
- ☐ COPD
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Duodenal ulcer
- ☐ Emphysema
- ☐ Esophageal reflux
- ☐ Gallbladder stones
- ☐ Gout
- ☐ Headache
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ IBD
- ☐ Insomnia
- ☐ Irregular heart rhythm
- ☐ Irritable bowel syndrome
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Palpatations
- ☐ Pancreatitis
- ☐ Peptic ulcer
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Seizures/epilepsy
- ☐ Sleep apnea
- ☐ Stroke (CVA)
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Varices
- ☐ Other:
  ____
  ____

Surgical History

Please check all that apply.

Procedure	Date	Procedure	Date	Procedure	Date
☐ Angioplasty	____________	☐ Colostomy	____________	☐ Open Reduction Internal Fixation	____________
☐ Angioplasty w/ stent	____________	☐ Gastric bypass	____________	☐ Pacemaker	____________
☐ Appendectomy	____________	☐ Hernia repair	____________	☐ Small bowel resection	____________
☐ Back surgery	____________	☐ Hip replacement	____________	☐ Thyroidectomy	____________
☐ Coronary Artery Bypass Graft	____________	☐ Knee replacement	____________	☐ Other:	
☐ Cholecystectomy	____________	☐ Knee arthroscopy	____________	____________________	
☐ Colectomy	____________	☐ Liver biopsy	____________		

Female Surgical History

Procedure	Date	Procedure	Date
☐ Bilateral tubal ligation	____________	☐ Myomectomy	____________
☐ Breast biopsy	____________	☐ Mammoplasty	____________
☐ Cesarean section	____________	☐ TAH/BSO (Total Abdominal Hysterectomy) / (Bilateral Salpingo-Oophorectomy)	____________
☐ D and C (Dilation and curettage)	____________		
☐ Hysterectomy	____________	☐ Other:	
☐ Mastectomy	____________	________________________________	____________

Male Surgical History

Procedure	Date	Procedure	Date
☐ Prostate biopsy	____________	☐ Vasectomy	____________
☐ TURP (Trans-Urethral Resection of the Prostate)	____________	☐ Other: ______________________________	____________

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