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John A Walker MD, FACG
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Gregory F Winters, MD
Jeani Buhl, FNP
Meghan Gilroy, MD
Adam M Mougey, MD

Hello!

You have been scheduled for our complementary educational class for Colonoscopy. We are pleased you have selected our office to be involved in your healthcare.

We have enclosed a Health History form for you to complete prior to your visit with us. Please check in 20 minutes prior to your appointment time so that our staff can complete your check-in process. Please bring your Insurance card (s), your government issued photo ID and medication list.

We are contracted with most major insurance carriers. If you have coverage or copay questions, please contact your insurance with these questions and let them know we are a Specialist office.

If you **do not** have Insurance you will need to pay a **$610 deposit** towards your procedure. You will need to pay your deposit for any services prior to scheduling. Please ask to meet with our billing department for any questions.

We do ask that if you are unable to keep your appointment, call our office 48 business hours prior to your appointment. Our normal business hours are Monday thru Thursday 8:00am to 5:00pm our number is 541-779-8367 option 1.

We look forward to seeing you!

Sincerely,
Gastroenterology Consultants

Gastroenterology Consultants, P.C .

Date:

Appointment Date:

Patient Name: **Date of Birth:** **Acct:**

Referring Physician: Primary Care Provider:

May we send a report to your physician? Yes ☐ No ☐

What is your chief complaint for today's visit?

ALLERGIES: Are you allergic to any medication: Yes ☐ NO☐ If yes please list medication and the reaction: _____

Have you had the Influenza Vaccine Yes ☐ No ☐ **Date:** _____
Pneumonia Vaccine Yes ☐ No ☐ **Date:** _____

Has anyone in your Immediate FAMILY had any of the following? ☐ None

	Who/Age?		Who/Age?
☐	Chronic Acid Reflux	☐	Liver Disease
☐	Colitis	☐	Pancreatic Cancer
☐	Colon Cancer	☐	Pancreatic Disease
☐	Colon Polyps	☐	Stomach Cancer
☐	Crohn's Disease	☐	Ulcer Disease
☐	Gallstones	☐	Other Cancer (type)?

Please list any past procedures and/or radiology tests you have had. ☐ None

	Date/Where:		Date/Where:
☐	Barium Enema	☐	Small Bowel Series
☐	Colonoscopy	☐	Ultrasound
☐	CT Scan	☐	Upper Endoscopy
☐	Liver Biopsy	☐	Upper GI Series
☐	Sigmoidoscopy	☐	Others, please list:

Please list any previous surgeries you have had. ☐ None

	Date/Where:		Date/Where:
☐	Appendix	☐	Hysterectomy Vaginal or Abdominal
☐	Colon	☐	Small Bowel
☐	Esophagus	☐	Cesarean
☐	Gallbladder	☐	Others, please list:
☐	Heart	☐	Others, please list:

Personal Habits

Alcohol	Yes ☐	No ☐	# per day?
Coffee	Yes ☐	No ☐	# per day?
Cola/Soda	Yes ☐	No ☐	# per day?
Illegal Drug Use	Yes ☐	No ☐	Type:

Tobacco:

☐ Never
☐ Former: year/age quit
☐ Current ___# per day cigarettes/chew/pipe/cigar

Marijuana ☐ Yes ☐ No
Do you have OMMP card? ☐ Yes ☐ No

Please mark below conditions you have had? OR Check here ☐ if NONE apply

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Hepatitis
- ☐ Blood Transfusion (year)? _____
- ☐ CAD (Coronary Artery Disease)
- ☐ Cancer (type)? _____
- ☐ CHF (Heart Failure)
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Pulmonary Hypertension
- ☐ Depression
- ☐ Diabetes I ☐ II ☐
- ☐ Diverticulitis
- ☐ Epilepsy
- ☐ Esophageal Stricture
- ☐ Fatty Liver
- ☐ Fecal Incontinence
- ☐ GERD (Acid Reflux)
- ☐ Hepatitis, B ☐ or C ☐
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Aortic Stenosis
- ☐ Migraine Headaches
- ☐ MRSA (Drug Resistant Staph)
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Pancreatic Disease
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Psychiatric Disorders
- ☐ Sleep Apnea with C-pap (level)? ____
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis
- ☐ Ulcers
- ☐ Other Conditions: _____ _____

Medications: It is important for your provider to know all of the medications you are taking (including supplements and over the counter medications) please bring a complete list with correct spelling, dosages and directions to all of your doctor's appointments.

Current Medications	Dose (mg, ml, mcg)	Directions

Marital Status: □ Married □ Single □ Widowed □ Divorced

Security Question: _____ **(City you were born in)**

Race of Patient: □ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian □ Other Race □ Other/Multi □ White **Ethnicity of Patient:** □ Hispanic or Latino □ Not Hispanic or Latino

Employer: _____ SS# _____