Gastroenterology Consultants, PC

Dear Patient,

We are pleased you have selected our office to be involved in your healthcare.

Please print and complete the Health History form for 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 **$350 deposit** towards your office visit, due at time of service, and then you will need to pay for any further 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, PC

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:
Marijuana	Yes ☐	No ☐	

Tobacco:

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

Height: _____ Weight: _____ BP: _____ Pulse: _____ Initials: _____ Date: _____

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
- ☐ Depression
- ☐ Diabetes I ☐ II ☐
- ☐ Diverticulitis
- ☐ Epilepsy
- ☐ Esophageal Stricture
- ☐ Fatty Liver
- ☐ Fecal Incontinence
- ☐ GERD (Acid Reflux)
- ☐ Hepatitis B or Hepatitis C ☐
- ☐ High Blood Pressure
- ☐ Pulmonary Hypertension
- ☐ 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

Please mark current conditions below OR Check here ☐ if NONE apply

CARDIOVASCULAR
- ☐ Ankle Swelling
- ☐ Chest Pain
- ☐ Palpitation

CONSTITUTIONAL
- ☐ Chills
- ☐ Fevers
- ☐ Weight Loss ☐ Gain

EYES, EARS, MOUTH
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Vision Loss
- ☐ Yellow Eyes

RESPIRATORY
- ☐ Cough
- ☐ Hoarseness
- ☐ Productive Cough
- ☐ Wheezing
- ☐ Shortness of breath

GASTROINTESTINAL
- ☐ Abdominal bloating
- ☐ Abdominal pain
- ☐ Accidental Bowel Leakage
- ☐ Black stools
- ☐ Blood with stools
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion (dyspepsia)
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Painful swallowing
- ☐ Rectal pain
- ☐ Regurgitation
- ☐ Vomiting
- ☐ Vomiting Blood

GENITOURINARY
- ☐ Blood in Urine
- ☐ Burning on Urination
- ☐ Frequent Urination

HEMATOLOGIC
- ☐ Easily Bleeds
- ☐ Swollen Glands

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Muscle Pain

NEUROLOGIC
- ☐ Fainting Spells
- ☐ Headaches
- ☐ Seizures

SKIN
- ☐ Itching
- ☐ Jaundice (Yellow Skin)
- ☐ Rashes

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#_____