Fax: 434-220-3781
Email: charlottesville@gastrohealth.com

GASTRO HEALTH

This form must be completed and returned to Gastro Health before an appointment is scheduled.

PATIENT INFORMATION FORM - SELF REFERRAL

Patient Information:

Last Name: _____ First Name: _____ DOB: _____

Legal Gender:_____ Home Phone: _____ Mobile Phone: _____ SS# _____

Preferred Phone: Home or Mobile (circle one) Email: _____

Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Occupation: _____ Employer: _____

Primary Care Provider (PCP): _____ PCP Phone: _____

Preferred Pharmacy: _____ Pharm Phone: _____

Preferred Pharmacy Address: _____

Insurance Information

PRIMARY

INSURANCE CARRIER

NAME OF POLICY HOLDER

INSURANCE ID NUMBER

SECONDARY

INSURANCE CARRIER

NAME OF POLICY HOLDER

INSURANCE ID NUMBER

Reason for appointment: _____

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems	□ Y	□ N	Heart Disease/Disorder	□ Y	□ N
Arthritis	□ Y	□ N	Lung Disorder	□ Y	□ N
Bleeding/Clotting Disorder	□ Y	□ N	Liver Disease	□ Y	□ N
Blood Pressure Disorder	□ Y	□ N	Neurological Disorder/Chronic Headaches	□ Y	□ N
Blood Transfusion	□ Y	□ N	Psychiatric Disorder/Illness	□ Y	□ N
Bowel/Stomach Problems	□ Y	□ N	Pulmonary Embolism/DVT	□ Y	□ N
Cancer	□ Y	□ N	Stroke	□ Y	□ N
Cholesterol Disorder	□ Y	□ N	Seizure or Epilepsy	□ Y	□ N
Diabetes	□ Y	□ N	Thyroid Disorder	□ Y	□ N
Eye Disorder (i.e. Glaucoma, cataract)	□ Y	□ N	Urinary/Kidney Disorder	□ Y	□ N

If Relevant: Gynecological Issues..... □ Y □ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

_____

_____

_____

Name:_____

DOB:_____

GASTRO HEALTH

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ N	

Do you currently smoke? □ Y □ N If no, previously? □ Y □ N Years smoked _____ Packs/day _____

Do you use other tobacco products? □ Y □ N Consume alcohol? □ Y □ N If yes, drinks/week: _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc…)

Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____
Doctor's Name: _____ Specialty: _____

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Name:_____

DOB:_____

GASTRO HEALTH

Review of Systems:

Please indicate if you had any of the following in the last 12 months.

Constitutional

□Y□N Fever	□Y□N Fatigue	□Y□N Weight Gain (___ Lbs)	□Y□N Sleep Disturbances
□Y□N Chills	□Y□N Feeling Poorly	□Y□N Weight Loss (___ Lbs)	□ Other:
	□Y□N Sweats	□Y□N Unexp. Weight Change	

Head, Eyes, Ears, Nose, and Throat

□Y□N Vision Problem	□Y□N Red Eyes	□Y□N Congestion	□Y□N Hoarseness
□Y□N Decreased Hearing	□Y□N Eye Pain	□Y□N Snoring	□Y□N Ringing in Ears
□Y□N Double Vision	□Y□N Runny Nose	□Y□N Dry Mouth	□Y□N Vertigo
□Y□N Light Sensitivity	□Y□N Neck Stiffness	□Y□N Flu-Like Symptoms	□Y□N Earache
□Y□N Itchy Eyes	□Y□N Nosebleed	□Y□N Sore Throat	□Y□N Other:

Cardiovascular

□Y□N Chest Pain	□Y□N Cold Extremities	□Y□N Irregular Heart Rhythm
□Y□N Palpitations	□Y□N Cold Hands or Feet	□Y□N Other:
□Y□N Leg Swelling	□Y□N Leg Pain w/ Walking	

Respiratory

□Y□N Shortness of Breath	□Y□N Wheezing	□Y□N Coughing Up Blood	□
□Y□N Cough	□Y□N Shortness of Breath	□Y□N Coughing Up Sputum	
□Y□N Rapid Breathing	□Y□N Chest Congestion	□ Other:	

Gastrointestinal

□Y□N Abdominal Pain	□Y□N Diarrhea	□Y□N Change in Bowels	□Y□N Painful Swallowing
□Y□N Blood in Stool	□Y□N Black/Tarry Stools	□Y□N Vomiting Blood	□ Other:
□Y□N Vomiting	□Y□N Decreased Appetite	□Y□N Bowel Incontinence	
□Y□N Nausea	□Y□N Yellow Skin	□Y□N Rectal Pain	
□Y□N Constipation	□Y□N Trouble Swallowing	□Y□N Heartburn	

Neurological

□Y□N Headache	□Y□N Unsteady	□Y□N Numbness	□Y□N Tremor
□Y□N Dizziness	□Y□N Disorientation	□Y□N Tingling	□Y□N Memory Lapses/Loss
□Y□N Decreased Strength	□Y□N Confusion	□Y□N Seizures	□ Other:
□Y□N Poor Coordination	□Y□N Burning Sensation	□Y□N Fainting (Syncope)	

Musculoskeletal

□Y□N Joint Pain	□Y□N Limb Pain	□Y□N Muscle Pain	□ Other:
□Y□N Neck Pain	□Y□N Joint Swelling	□Y□N Muscle Weakness	
□Y□N Back Pain	□Y□N Muscle Cramps	□Y□N Leg Swelling	

Genitourinary

□Y□N Frequent Urination	□Y□N Pelvic Pain	□Y□N Painful Intercourse	□Y□N Heavy Period Bleeding
□Y□N Incontinence	□Y□N Nocturia	□Y□N Discharge- Vaginal	□ Other:
□Y□N Urinary Urgency	□Y□N Itching- Genital	□Y□N Vaginal Bleeding	
□Y□N Painful Urination	□Y□N Change in Libido	□Y□N Irreg. Monthly Cycles	

Integumentary

□Y□N Rash	□Y□N Skin Wound	□Y□N Unusual Growth	□Y□N Skin Cancer
□Y□N Dry Skin	□Y□N Change in A Mole	□Y□N Itching	□ Other:

Psychiatric

□Y□N Depression	□Y□N Anxiety	□Other:

Hematologic/Lymphatic

□Y□N Easy Bruising	□Y□N Easy Bleeding	□Y□N Swollen Lymph Nodes	□ Other:

Endocrine

□Y□N Excessive Thirst	□Y□N Heat Intolerance	□Y□N Changes- Skin
□Y□N Cold Intolerance	□Y□N Changes- Hair	□ Other: