GASTROHEALTH

RECALL FORM

Name: _____ Date of Birth: _____ Age:_____

Procedure: _____ Provider:_____

Our team requires this completed form and your insurance information prior to scheduling any procedure. We will contact you once your provider has reviewed the information.

	YES	NO
1. Do you have any heart problems? *Ex. congestive heart failure, atrial fibrillation*	☐	☐
Have you ever had a heart attack?	☐	☐
Have you ever had heart surgery? Ex. Open heart, stent(s), artificial valve	☐	☐
When? _____	☐	☐
Pacemaker or Internal Defibrillator		
If yes, please explain _____		
Who is your cardiologist? _____		
2. Do you take medication for high blood pressure or heart disease?	☐	☐
If so, who is the prescribing doctor? _____		
3. Do you have any kidney problems? _____	☐	☐
Are you currently on dialysis?	☐	☐
4. Have you ever had a stroke?	☐	☐
If so, when? _____		
Any impairment from it? _____		
5. Do you take any blood thinners? Ex. Plavix (clopidogrel), Pletal (cilostazol), Effient (prasugril), Brilinta (ticagrelor), Coumadin (warfarin), Pradaxa (dabigatran), Xarelto (rivaroxaban), Eliquis (apixaban), Lovenox, Savaysa (edoxaban), Aspirin?	☐	☐
If yes, why? _____		
Who is your prescribing doctor? _____		
6. Do you have any respiratory problems? Ex. tuberculosis, emphysema, COPD, asthma	☐	☐
If yes, please explain _____		
7. Have you ever been diagnosed with sleep apnea?	☐	☐
If yes, do you use a C-Pap/Bi-Pap machine? _____		
8. Have you ever had any serious problems with Anesthesia? Ex. Hard to intubate, stopped breathing, dangerously high/low blood pressure, injuries to your nose, neck or back	☐	☐
If yes, please explain _____		
9. Do you have any other health problems or changes in your health status?	☐	☐
If yes, please explain _____		
10. Have you been hospitalized in the past 30 days?	☐	☐
If so, why? _____+_____		
11. Do you (the patient) live in a nursing home / assisted living facility?	☐	☐
12. What is your approximate weight? _____lbs. and height?_____ BMI _____		
13. Who is your family physician? _____		

****PLEASE LIST THE PHONE NUMBER TO REACH YOU DURING BUSINESS HOURS****

Home: _____ Cell: _____ Work: _____

Name:	Date:
PLEASE LIST ALL CURRENT MEDICATIONS, OVER THE COUNTER DRUGS, HERBAL SUPPLEMENTS AND VITAMINS BELOW	
IF YOU ARE NOT TAKING ANY OF THE ABOVE, PLEASE CHECK: NONE ☐	
EXAMPLE: NEXIUM	*40mg 1 tab once daily*

PLEASE LIST ALL ALLERGIES BELOW:	
IF YOU ARE NOT TAKING ANY OF THE ABOVE, PLEASE CHECK: NONE ☐	
EXAMPLE: PENICILLIN	*HIVES*

PLEASE PROVIDE THE FOLLOWING INSURANCE INFORMATION:

*1st Insurance _____Holder _____DOB:_____SSN:_____

Policy/ID# _____ Group # _____ Employer _____

Claims Address _____

Benefit/Eligibility/Provider Service Phone #: _____

*2nd Insurance _____Holder _____DOB:_____SSN:_____

Policy/ID# _____ Group # _____ Employer _____

Claims Address _____

Benefit/Eligibility/Provider Service Phone #: _____

Patient Employer (if different than Ins. Holder): _____

Please email a copy of this completed form and a copy of your insurance card (front and back) to LimaRecalls@GastroHealth.com