GASTROHEALTH

FAST TRACK – PATIENT INFORMATION FORM

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	SECONDARY
INSURANCE CARRIER	INSURANCE CARRIER
NAME OF POLICY HOLDER	NAME OF POLICY HOLDER
INSURANCE ID NUMBER	INSURANCE ID NUMBER

Reason for Appointment: Screening or Surveillance - Colonoscopy / Endoscopy / Flexible Sigmoidoscopy (circle)

General Medical Questionnaire

Height:_____ Weight:_____

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 Headache	□ 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:_____

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