Fax: 434-220-3781

1139 E. High St., Suite 203
Charlottesville, VA 22902

GASTRO HEALTH

PATIENT INFORMATION FORM - OPEN ACCESS

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

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:_____

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:_____

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

Review of Systems:

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: