

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

Reason for appointment: _____

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems..... <input type="checkbox"/> Y <input type="checkbox"/> N	Heart Disease/Disorder <input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis..... <input type="checkbox"/> Y <input type="checkbox"/> N	Lung Disorder..... <input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding/Clotting Disorder..... <input type="checkbox"/> Y <input type="checkbox"/> N	Liver Disease <input type="checkbox"/> Y <input type="checkbox"/> N
Blood Pressure Disorder..... <input type="checkbox"/> Y <input type="checkbox"/> N	Neurological Disorder/Chronic Headaches.. <input type="checkbox"/> Y <input type="checkbox"/> N
Blood Transfusion <input type="checkbox"/> Y <input type="checkbox"/> N	Psychiatric Disorder/Illness..... <input type="checkbox"/> Y <input type="checkbox"/> N
Bowel/Stomach Problems..... <input type="checkbox"/> Y <input type="checkbox"/> N	Pulmonary Embolism/DVT <input type="checkbox"/> Y <input type="checkbox"/> N
Cancer..... <input type="checkbox"/> Y <input type="checkbox"/> N	Stroke..... <input type="checkbox"/> Y <input type="checkbox"/> N
Cholesterol Disorder <input type="checkbox"/> Y <input type="checkbox"/> N	Seizure or Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes..... <input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid Disorder <input type="checkbox"/> Y <input type="checkbox"/> N
Eye Disorder (i.e. Glaucoma, cataract) <input type="checkbox"/> Y <input type="checkbox"/> N	Urinary/Kidney Disorder <input type="checkbox"/> Y <input type="checkbox"/> N
If Relevant: Gynecological Issues..... <input type="checkbox"/> Y <input type="checkbox"/> N	

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

DOB: _____

[illegible]

Relative	Condition and description	Living?	If deceased, at what age?
Mother		<input type="checkbox"/> Y <input type="checkbox"/> N	
Father		<input type="checkbox"/> Y <input type="checkbox"/> N	
Sibling		<input type="checkbox"/> Y <input type="checkbox"/> N	
Other:		<input type="checkbox"/> Y <input type="checkbox"/> N	

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

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

[illegible]

Name: _____

DOB: _____

Review of Systems:

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

Constitutional

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue | <input type="checkbox"/> Y <input type="checkbox"/> N Weight Gain (___ Lbs) | <input type="checkbox"/> Y <input type="checkbox"/> N Sleep Disturbances |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chills | <input type="checkbox"/> Y <input type="checkbox"/> N Feeling Poorly | <input type="checkbox"/> Y <input type="checkbox"/> N Weight Loss (___ Lbs) | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Y <input type="checkbox"/> N Sweats | <input type="checkbox"/> Y <input type="checkbox"/> N Unexp. Weight Change | |

Head, Eyes, Ears, Nose, and Throat

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Vision Problem | <input type="checkbox"/> Y <input type="checkbox"/> N Red Eyes | <input type="checkbox"/> Y <input type="checkbox"/> N Congestion | <input type="checkbox"/> Y <input type="checkbox"/> N Hoarseness |
| <input type="checkbox"/> Y <input type="checkbox"/> N Decreased Hearing | <input type="checkbox"/> Y <input type="checkbox"/> N Eye Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Snoring | <input type="checkbox"/> Y <input type="checkbox"/> N Ringing in Ears |
| <input type="checkbox"/> Y <input type="checkbox"/> N Double Vision | <input type="checkbox"/> Y <input type="checkbox"/> N Runny Nose | <input type="checkbox"/> Y <input type="checkbox"/> N Dry Mouth | <input type="checkbox"/> Y <input type="checkbox"/> N Vertigo |
| <input type="checkbox"/> Y <input type="checkbox"/> N Light Sensitivity | <input type="checkbox"/> Y <input type="checkbox"/> N Neck Stiffness | <input type="checkbox"/> Y <input type="checkbox"/> N Flu-Like Symptoms | <input type="checkbox"/> Y <input type="checkbox"/> N Earache |
| <input type="checkbox"/> Y <input type="checkbox"/> N Itchy Eyes | <input type="checkbox"/> Y <input type="checkbox"/> N Nosebleed | <input type="checkbox"/> Y <input type="checkbox"/> N Sore Throat | <input type="checkbox"/> Y <input type="checkbox"/> N Other: |

Cardiovascular

- | | | |
|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Cold Extremities | <input type="checkbox"/> Y <input type="checkbox"/> N Irregular Heart Rhythm |
| <input type="checkbox"/> Y <input type="checkbox"/> N Palpitations | <input type="checkbox"/> Y <input type="checkbox"/> N Cold Hands or Feet | <input type="checkbox"/> Y <input type="checkbox"/> N Other: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Leg Swelling | <input type="checkbox"/> Y <input type="checkbox"/> N Leg Pain w/ Walking | |

Respiratory

- | | | | |
|---|---|--|--------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath | <input type="checkbox"/> Y <input type="checkbox"/> N Wheezing | <input type="checkbox"/> Y <input type="checkbox"/> N Coughing Up Blood | <input type="checkbox"/> |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath | <input type="checkbox"/> Y <input type="checkbox"/> N Coughing Up Sputum | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rapid Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Chest Congestion | <input type="checkbox"/> Other: | |

Gastrointestinal

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea | <input type="checkbox"/> Y <input type="checkbox"/> N Change in Bowels | <input type="checkbox"/> Y <input type="checkbox"/> N Painful Swallowing |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood in Stool | <input type="checkbox"/> Y <input type="checkbox"/> N Black/Tarry Stools | <input type="checkbox"/> Y <input type="checkbox"/> N Vomiting Blood | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Vomiting | <input type="checkbox"/> Y <input type="checkbox"/> N Decreased Appetite | <input type="checkbox"/> Y <input type="checkbox"/> N Bowel Incontinence | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Nausea | <input type="checkbox"/> Y <input type="checkbox"/> N Yellow Skin | <input type="checkbox"/> Y <input type="checkbox"/> N Rectal Pain | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Constipation | <input type="checkbox"/> Y <input type="checkbox"/> N Trouble Swallowing | <input type="checkbox"/> Y <input type="checkbox"/> N Heartburn | |

Neurological

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Headache | <input type="checkbox"/> Y <input type="checkbox"/> N Unsteady | <input type="checkbox"/> Y <input type="checkbox"/> N Numbness | <input type="checkbox"/> Y <input type="checkbox"/> N Tremor |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N Disorientation | <input type="checkbox"/> Y <input type="checkbox"/> N Tingling | <input type="checkbox"/> Y <input type="checkbox"/> N Memory Lapses/Loss |
| <input type="checkbox"/> Y <input type="checkbox"/> N Decreased Strength | <input type="checkbox"/> Y <input type="checkbox"/> N Confusion | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Poor Coordination | <input type="checkbox"/> Y <input type="checkbox"/> N Burning Sensation | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting (Syncope) | |

Musculoskeletal

- | | | | |
|--|--|---|---------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Joint Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Limb Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Pain | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Neck Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Joint Swelling | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Weakness | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Cramps | <input type="checkbox"/> Y <input type="checkbox"/> N Leg Swelling | |

Genitourinary

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Urination | <input type="checkbox"/> Y <input type="checkbox"/> N Pelvic Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Painful Intercourse | <input type="checkbox"/> Y <input type="checkbox"/> N Heavy Period Bleeding |
| <input type="checkbox"/> Y <input type="checkbox"/> N Incontinence | <input type="checkbox"/> Y <input type="checkbox"/> N Nocturia | <input type="checkbox"/> Y <input type="checkbox"/> N Discharge- Vaginal | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Y <input type="checkbox"/> N Urinary Urgency | <input type="checkbox"/> Y <input type="checkbox"/> N Itching- Genital | <input type="checkbox"/> Y <input type="checkbox"/> N Vaginal Bleeding | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Painful Urination | <input type="checkbox"/> Y <input type="checkbox"/> N Change in Libido | <input type="checkbox"/> Y <input type="checkbox"/> N Irreg. Monthly Cycles | |

Integumentary

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Rash | <input type="checkbox"/> Y <input type="checkbox"/> N Skin Wound | <input type="checkbox"/> Y <input type="checkbox"/> N Unusual Growth | <input type="checkbox"/> Y <input type="checkbox"/> N Skin Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dry Skin | <input type="checkbox"/> Y <input type="checkbox"/> N Change in A Mole | <input type="checkbox"/> Y <input type="checkbox"/> N Itching | <input type="checkbox"/> Other: |

Psychiatric

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Depression | <input type="checkbox"/> Y <input type="checkbox"/> N Anxiety | <input type="checkbox"/> Other: |
|--|---|---------------------------------|

Hematologic/Lymphatic

- | | | | |
|---|---|---|---------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N Easy Bruising | <input type="checkbox"/> Y <input type="checkbox"/> N Easy Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Swollen Lymph Nodes | <input type="checkbox"/> Other: |
|---|---|---|---------------------------------|

Endocrine

- | | | |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Excessive Thirst | <input type="checkbox"/> Y <input type="checkbox"/> N Heat Intolerance | <input type="checkbox"/> Y <input type="checkbox"/> N Changes- Skin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cold Intolerance | <input type="checkbox"/> Y <input type="checkbox"/> N Changes- Hair | <input type="checkbox"/> Other: |