Gastroenterology
OF SOUTHERN INDIANA
a division of GASTROENTEROLOGY HEALTH PARTNERS

2630 Grant Line Road
New Albany, IN 47150
812-945-0145 ph
812-949-5435 fx

Thank you for choosing Gastroenterology Health Partners for your digestive health. Please complete the three attached forms and then either:

1. Print them off and bring with you to your appointment
2. Print them off and fax them to the appropriate number at left
3. E-mail these forms to Alicia Prince at APrince@ghpsi.com

If you have any questions, please feel free to call 812-945-0145.

Thank you for helping be ecologically conscious by being paperless.

Procedure Scheduling Form Choose Procedure

Date:_____ Doctor: GHP Physician__ Account:_____

Please fill in all information listed below to assure your appointment is scheduled for your convenience and all major health issues are taken into consideration for safety of your preparation prior to the procedure.

YOU ARE SEDATED FOR THESE PROCEDURES AND WILL NEED SOMEONE TO DRIVE YOU HOME AFTERWARD.

Patient:_____ DOB:_____
First Last

Procedure will be performed at Physicians Medical Center unless we do not participate with your insurance plan.

Schedule procedure on: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Any

Is there any specific date(s) **good** for you? _____

Is there any specific date(s) **not good** for you? _____

Are you allergic to latex? ◯ yes ◯ no

Are you a diabetic? ◯ yes ◯ no
If yes, controlled by: ☐ Diet
☐ Medicine
Name: _____
Dosage_____
☐ Insulin - dosage_____

Do you take medications for: ☐ Arthritis _____
☐ Heart disease _____
☐ Blood thinner _____

Do you have an artificial heart valve? ◯ yes ◯ no
If yes, do you receive antibiotics prior to dental work or surgery? ◯ yes ◯ no

Do you have a pacemaker? ◯ Yes ◯ no
If yes, list brand and model_____

Do you have a personal history of cancer? ◯ Yes ◯ no Who/Type_____

Please be aware that if a procedure needs to be rescheduled it could take up to 4-6 weeks depending on the physicians' schedules. We appreciate and encourage that you make every effort to keep your appointment.

Patient Information Form
www.ghpsi.com

Gastroenterology
HEALTH PARTNERS

2630 Grant Line Road
New Albany, IN 47150
PHONE 812-945-0145 FAX 812-949-5435

ACCOUNT #_____

LAST NAME:	FIRST NAME:	MI:
ADDRESS:		
CITY:	STATE:	ZIP CODE:

DATE OF BIRTH:	SOCIAL SECURITY #:	SEX: Fema	MARITAL STATUS: Marital Status
PHONE NUMBERS: HOME	WORK	CELL	
EMAIL ADDRESS:	CAN WE CONTACT YOU BY EMAIL? ☐		
EMPLOYER:			
SPOUSE/PARTNER:		DATE OF BIRTH	
EMERGENCY CONTACT NAME:	RELATION:	PHONE:	
PRIMARY CARE PHYSICIAN:	REFERRING PHYSICIAN:		

PRIMARY INSURANCE:		
ADDRESS:		
POLICY NUMBER:	GROUP NUMBER:	
PHONE: COPAY:	EFFECTIVE DATE:	
POLICY HOLDER NAME:	DATE OF BIRTH:	
EMPLOYER:		

SECONDARY INSURANCE:		
ADDRESS:		
POLICY NUMBER:	GROUP NUMBER:	
PHONE: COPAY:	EFFECTIVE DATE:	
POLICY HOLDER NAME:	DATE OF BIRTH:	
EMPLOYER:		

INSURANCE AUTHORIZATION:

I request that payment of authorized benefits be made either to me or on my behalf to the above provider for services furnished by that physician. I authorize release to the indicated insurance carrier any medical information about me needed to determine these payments for related services. I understand that I am responsible for all fees regardless of insurance.

SIGNATURE:	**DATE:**

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Race

- ☐ White/Caucasian
- ☐ Black or African American
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Mixed
- ☐ Other
- ☐ Unknown
- ☐ Patient declines to provide information
- ☐ Prohibited by state law

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to provide information
- ☐ Prohibited by state law

Preferred Language

Other:_____

Allergies

- ☐ Patient has no known allergies
- ☐ Patient has no known drug allergies
- ☐ Aspirin
- ☐ Iodine
- ☐ Penicillins
- ☐ Sulfa (Sulfonamides)
- ☐ Versed
- ☐ Dairy products
- ☐ Latex
- ☐ codeine sulfate

Other:_____

Current Medications

- ☐ None

Name	Dose	How taken?

Pharmacy

Name:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed
- ◯ Civil Union
- ◯ Unknown
- ◯ Other

Alcohol

- ☐ None

	Type Alcoholic Drink	Quantity	Frequency Times / week
☐			

Caffeine

- ☐ None

Tobacco

Smoking Status

- ◯ Current every day smoker
- ◯ Current some day smoker
- ◯ Former smoker
- ◯ Never smoker
- ◯ Smoker, current status unknown
- ◯ Unknown if ever smoked

	Type Cigarettes	Started	Quit	Quantity	Frequency Cigarettes / Day
☐					

Drug Use

- ☐ None

	Type Recreational Drugs	Quantity	Frequency Times / week
☐			

Exercise

- ☐ None

Previous Procedures

- ☐ None
- ☐ Appendectomy
- ☐ Capsule Endoscopy
- ☐ Cardiac (CABG)
- ☐ Cardiac (VALVE)
- ☐ Colon Polyp Removal
- ☐ Colon Resection
- ☐ Colonoscopy
- ☐ Colostomy
- ☐ C-Section
- ☐ ERCP
- ☐ Gallbladder
- ☐ Groin Hernia
- ☐ Hemorrhoid
- ☐ Hiatal Hernia
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Kidney
- ☐ Liver Biopsy
- ☐ Obesity Surgery
- ☐ Ovary surgery
- ☐ Pacemaker/Defibrillator
- ☐ Prostate Surgery
- ☐ Radiation Therapy-Abdomen
- ☐ Radiation Therapy-Chest
- ☐ Radiation Therapy-Head/Neck
- ☐ Radiation Therapy-Ovary
- ☐ Radiation Therapy-Prostate
- ☐ Stomach
- ☐ Thyroid
- ☐ Tubal Ligation
- ☐ Upper/EGD
- ☐ Heart Stent Placement
- ☐ Artificial Heart Valve
- ☐ Dialysis

Other:_____

Past or Present Medical Conditions

☐ None

GI Related Illnesses

☐ Cirrhosis ☐ Colon polyps ☐ Crohn's Disease ☐ Diverticulitis
☐ Esophagitis/GERD ☐ Gallstones ☐ Groin Hernia ☐ Hepatitis
☐ Irritable Bowel ☐ Pancreatitis ☐ Stomach/Duodenum Ulcer ☐ Ulcerative Colitis

Other:_____

Other Illnesses

☐ Abnormal Bleeding ☐ Abnormal Blood Clotting/Blood Clots ☐ Anemia ☐ Arterial Blockages
☐ Asthma ☐ Blood Transfusions ☐ Breast cancer ☐ Chronic Headache
☐ Chronic Pain for less than 6 months ☐ Colon cancer ☐ Diabetes Mellitus ☐ Emphysema
☐ Endometriosis ☐ Fibromyalgia ☐ Frequent Urinary Infections ☐ Heart Disease
☐ Heart Failure ☐ Heart Murmurs ☐ High Blood Pressure ☐ High Chlolesterol
☐ HIV/AIDS ☐ Irregular Heart Beat ☐ Kidney Disease/Failure ☐ kidney stones
☐ Lupus ☐ Melanoma ☐ Multiple Sclerosis ☐ Osteoporosis
☐ Ovarian Cancer ☐ Ovarian Cyst ☐ Parkinson's Disease ☐ Pneumonia
☐ Prostate Cancer ☐ Psoriasis ☐ Rheumatic Fever ☐ Seizures
☐ Sexually Transmitted Disease ☐ Sleep apnea ☐ Stroke or Paralysis ☐ TB or Positive TB Skin Test
☐ Thyroid Disease ☐ Deep vein thrombosis (blood clot in leg) ☐ Pulmonary embolus (blood clot in lung) ☐ CVA (stroke)
☐ TIA Other:_____

Diagnostic Studies / Tests

☐ None

☐ Labs When:_____ ☐ Xray/Radiology When:_____

Immunizations

☐ None

☐ Flu vaccine ☐ Hepatitis A ☐ Hepatitis B ☐ HPV ☐ Meningococcal

☐ Pneumoccocal ☐ Tdap

Family Medical History

☐ No knowledge of family history

No family history of ☐ Colon cancer ☐ Colon Polyps

Health Status	Mother	Father	Sister	Brother	Daughter	Son
Age/Date of Birth						
Family Hx of Colon Cancer	☐	☐	☐	☐	☐	☐
Family Hx of Colon Polyps	☐	☐	☐	☐	☐	☐
Family Hx of Celiac Disease	☐	☐	☐	☐	☐	☐
Family Hx of Colitis	☐	☐	☐	☐	☐	☐
Family Hx of Crohn's Disease	☐	☐	☐	☐	☐	☐
Family Hx of Liver Disease	☐	☐	☐	☐	☐	☐
Family Hx of Breast Cancer	☐	☐	☐	☐	☐	☐
Family Hx of Esophageal Cancer	☐	☐	☐	☐	☐	☐
Family Hx of Ovarian Cancer	☐	☐	☐	☐	☐	☐
Family Hx of Pancreatic Cancer	☐	☐	☐	☐	☐	☐
Family Hx of Stomach Cancer	☐	☐	☐	☐	☐	☐
Family Hx of Uterine Cancer	☐	☐	☐	☐	☐	☐

Review Of Systems

Cardiovascular	Yes	No
ankle swelling	○	○
chest pain	○	○
irregular heart beat	○	○
shortness of breath	○	○

Constitutional	Yes	No
fatigue	○	○
fever	○	○
loss of appetite	○	○
weight loss	○	○
weight gain	○	○

ENMT	Yes	No
hearing loss	○	○
hoarseness	○	○
sore throat	○	○
nose bleeds	○	○

Endocrine	Yes	No
excessive thirst	○	○
cold intolerance	○	○
heat intolerance	○	○

Eyes	Yes	No
light sensitivity	○	○
eye pain	○	○
visual decline	○	○

Gastrointestinal	Yes	No
abdominal pain	○	○
belching	○	○
black stools	○	○
bloating	○	○
change in bowel habits	○	○
constipation	○	○
dairy incontinence	○	○
diarrhea	○	○
difficulty swallowing	○	○
painful swallowing	○	○
flatulence/rectal gas	○	○
heartburn/reflux	○	○
mucous in stools	○	○
nausea	○	○
painful stools	○	○
rectal protusions	○	○
rectal urgency	○	○
soiling/incontinence	○	○
vomiting	○	○

Genitourinary	Yes	No
blood in urine	○	○
burning urination	○	○

Hematologic/Lymphatic	Yes	No
easy bruising	○	○
prolonged bleeding	○	○
abnormal blood clotting	○	○

Integumentary	Yes	No
itching	○	○
jaundice	○	○
rash	○	○
suspicious lesions	○	○

Musculoskeletal	Yes	No
back pain	○	○
joint pain	○	○
muscle pain	○	○

Neurological	Yes	No
dizziness	○	○
fainting	○	○
frequent headaches	○	○
loss of consciousness	○	○

Psychiatric	Yes	No
anxiety/panic	○	○
depression	○	○
difficulty sleeping	○	○

Respiratory	Yes	No
coughing blood	○	○
chronic cough	○	○
painful breathing	○	○