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PHARMACY INFORMATION

- NAME:_____
- PHONE NUMBER:_____
- CROSS STREETS:_____
- CITY: _____

EMAIL ADDRESS

_____

PRIMARY CARE INFORMATION

- PRIMARY CARE PHSYCIAN:_____
- PHONE NUMBER:_____

HIPPA

NAME:_____ RELATIONSHIP:_____

NAME:_____ RELATIONSHIP:_____

I ACKNOWLEDGE THAT THERE IS A $25.00 "NO CALL, NO SHOW FEE" IF I DON'T SHOW TO A SCHEDULED APPOINTMENT IF I DO NOT CALL AND CANCEL WITH THE OFFICE WITHIN 24 HOURS PRIOR TO MY APPOINTMENT.

SIGNATURE:_____

Patient Health History

Reason for visit:_____

Describe your symptoms:_____

Please indicate yes or no if you have any of the symptoms listed below. Do you now, or do you have a history of:

GASTROINTESTINAL

Poor appetite	☐Yes	☐No
Difficulty in swallowing	☐Yes	☐No
Heartburn	☐Yes	☐No
Nausea or vomiting	☐Yes	☐No
Bloating	☐Yes	☐No
Belching	☐Yes	☐No
Regurgitation	☐Yes	☐No
Constipation	☐Yes	☐No
Diarrhea	☐Yes	☐No
Abdominal pain	☐Yes	☐No
Changes in bowel habits	☐Yes	☐No
Rectal bleeding	☐Yes	☐No
Jaundice	☐Yes	☐No
Ulcer	☐Yes	☐No
Black, tarry stools	☐Yes	☐No

CONSTITUTIONAL

Recent weight change	☐Yes	☐No
Fever	☐Yes	☐No
Fatigue	☐Yes	☐No
Night Sweats	☐Yes	☐No
Infections/Injuries	☐Yes	☐No

EYES

Blurred vision	☐Yes	☐No
Infections/Injuries	☐Yes	☐No
Double/blurred vision	☐Yes	☐No

EARS/NOSE/MOUTH

Hearing loss	☐Yes	☐No
Ringing in ears	☐Yes	☐No
Mouth sores	☐Yes	☐No
Sore throat	☐Yes	☐No

CARDIOVASCULAR

Shortness of breath	☐Yes	☐No
Swelling of ankles/feet	☐Yes	☐No
Heart murmur	☐Yes	☐No
Irregular pulse	☐Yes	☐No

RESPIRATORY

Chronic cough	☐Yes	☐No
Spitting up blood	☐Yes	☐No
Wheezing	☐Yes	☐No

SKIN

Rash	☐Yes	☐No
Itching	☐Yes	☐No

GENITOURINARY

Burning with urination	☐Yes	☐No
Blood in urine	☐Yes	☐No
Frequent/urgent urination	☐Yes	☐No
Incontinence	☐Yes	☐No

NEUROLOGICAL

Headaches	☐Yes	☐No
Numbness	☐Yes	☐No
Disorientation	☐Yes	☐No
Weakness	☐Yes	☐No

ENDOCRINE

Heat or cold intolerance	☐Yes	☐No
Excessive thirst/urination	☐Yes	☐No

HEMATOLOGICAL

Bleeding/bruising	☐Yes	☐No
Swollen glands	☐Yes	☐No

MUSCULOSKELETAL

Joint/muscle pain	☐Yes	☐No
Muscle pain	☐Yes	☐No
Arm/leg weal/numbness	☐Yes	☐No
Back/neck pain	☐Yes	☐No

PSYCHIATRIC

Memory loss or confusion	☐Yes	☐No

To expedite prescription prior authorizations indicate if you have ever taken any of the following medications:

Medication	Yes	Dates (if known)	Medication	Yes	Dates (if known)	Medication	Yes	Dates (if known)
Aciphex			Fibersure			Pantoprazole		
Amitiza			Glycolax			Pepcid		
Benefiber			Kapidex			Prevacid		
Citrucel			Kristalose			Prilosec		
Correctol			Lactulose			Protonix		
Dexilant			Lansoprazole			Reglan		
Dulcolax			Metamucil			Tagamet		
Dulcolax Balance			Nexium			Zantac		
Exlax			Omeprazole			Zegerid		
Fibercon			Pantoprazole			Other		

Patient Signature:_____ Date:_____

«FullNameFML» «PatientId»

MEDICAL HISTORY: Please check to indicate if you have any history of the following disorders

- ☐ Emphysema
- ☐ Pneumonia/ Bronchitis
- ☐ Arthritis
- ☐ Depression
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Blood Disorder
- ☐ Liver Disease
- ☐ Hepatitis/ HIV
- ☐ Ulcer
- ☐ Crohns
- ☐ Pancreatitis
- ☐ IBS
- ☐ Ulcerative Colitis
- ☐ Weight Loss
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Irregular Pulse
- ☐ Pacemaker/Defibrillator
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Heart Problems: _____
- ☐ Kidney Failure/Dialysis
- ☐ Seizure
- ☐ Stroke
- ☐ Glaucoma
- ☐ Thyroid
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Cancer: _____
- ☐ Colon Polyps
- ☐ Learning Disabilities
- ☐ Physical Limitations

Please list any other major illness: _____

_____

SURGICAL HISTORY: Please check to indicate if you have any history of the following operations

☐ Colostomy ☐ Ileostomy ☐ Gastric Bypass/ Banding ☐ Joint replacement ☐ Metal implant ☐ IV Port

☐ Filters ☐ Stents (biliary cardiac, colon) ☐ Pacemaker ☐ Defibrillator

Please list all major operations: _____

_____

Have you ever had? ☐Colonoscopy ☐EGD ☐ Upper GI ☐ Barium Enema ☐ Ultrasound ☐ Abdominal CT/ MRI

If yes, where? _____

SOCIAL: Please indicate your consumption of the following as they are important to GI disorders

	DO YOU CONSUME?	HOW OFTEN?	AMOUNT
Alcohol	☐ Yes ☐ No	_____	_____
Nicotine	☐ Yes ☐ No	_____	_____
Caffeine	☐ Yes ☐ No	_____	_____
Recreational Drugs	☐ Yes ☐ No (Marijuana, cocaine, etc.)	_____	_____
Domestic Violence	☐ Yes ☐ No		

FAMILY HISTORY: Please complete the following information for your blood relatives:

	Father	Mother	Brother(s)	Sister(s)	Other:
Deceased	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer History:					
Colon	☐	☐	☐	☐	☐
Esophageal	☐	☐	☐	☐	☐
Pancreatic	☐	☐	☐	☐	☐
Uterine/Breast	☐	☐	☐	☐	☐
Other (specify)	☐ _____	☐ _____	☐ _____	☐ _____	☐
Digestive History:					
Crohns	☐	☐	☐	☐	☐
Reflux	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐
Other (Specify)	☐ _____	☐ _____	☐ _____	☐ _____	☐
Cardiac History:	☐ _____	☐ _____	☐ _____	☐ _____	☐

Patient Signature: _____ Date: _____

«FullNameFML» «PatientId»

Name: _____

Date Updated: _____

LIST OF CURRENT MEDICINES (continued):

List all tablets, patches, inhalers, drops, liquids, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, nitroglycerin).

Medicine (Brand and generic name)	Dose	How and how often you take the medicine	Reason for taking	Date started	Date stopped	Doctor name