

Athens Gastroenterology Center

PATIENT HISTORY

PPE: Yes No EGD EGD-DIL FLEX-SIG COLONOSCOPY ERCP
 Hospital: ARMC SMH Date of Procedure: _____ Time: _____ SSN: _____
 Patients Name: _____ DOB: _____ Sex: _____ Date: _____
 Address: _____ Home Telephone: _____
 Place of Employment: _____ Work Telephone: _____
 Referring Physician: _____ Reason for referral: _____
 How Long: _____ Severity: _____ Treatment: _____
 Age: _____ Wt: _____ BP: _____ P: _____ Allergies: _____

____ Stroke/Seizure	____ Liver Disease	____ Stomach/Digestion
____ Heart Disease	____ Hepatitis	____ Colitis
____ High Blood Pressure	____ Bleeding Disorders	____ Crohn's Disease
____ Lung Disease	____ Blood Transfusion	____ Diabetes
____ Asthma	____ Anemia	____ Cancer
____ Tuberculosis	____ Kidney Disease	____ Depression
____ Mitral Valve Pro	____ Art Hip/Jnt replaced	____ Stools per day
____ Change in Bowel Habits ____ Dia ____ Const	____ Change in Appetite	____ Rectal Bleeding ____ Color ____ Amt
____ Travel out of country	City/Well Water	____ Are You Pregnant?

Other chronic illnesses: _____

Have you ever had any problems with anesthesia? _____

Past surgical procedures: _____

Family History: Cancer: Yes/No Organ of origin _____ Age Dx: _____
 Polyps: Yes/No Where? _____ What type? _____ Age Dx: _____
 Ulcers: Yes/No

Social History: Do you use tobacco products? ____ Yes ____ No How much? _____ How long? _____
 Do you drink alcohol? ____ Yes ____ No How much? _____ How long? _____

PATIENT HISTORY CONT'D

Name: _____ DOB: _____ Sex: _____

Have you ever had any of the following tests?

EGD	_____ Yes _____ No	When _____	Where _____
Upper GI	_____ Yes _____ No	When _____	Where _____
Colonoscopy	_____ Yes _____ No	When _____	Where _____
Flex Sig	_____ Yes _____ No	When _____	Where _____
Barium enema	_____ Yes _____ No	When _____	Where _____
Ultra Sound	_____ Yes _____ No	When _____	Where _____

Medications: _____

Genotype	Viral Load	Int. Nurse Visit	PCR Ordered	Counselor Consult
Meds Ordered		Liver Bx Date		Inj. Teaching Date

Physician Comments: _____

Other Orders: _____

Medical Assistant/Nurse Practitioner Signature

Physician Signature

INSURANCE INFORMATION

Policy Name: _____ Group # _____ ID # _____

Ins. Address: _____

Number for Precert: _____ Policy is in whose name? _____

Address of Policy Holder: _____ Relationship to Patient: _____

Date of Birth of Policy Holder: _____

Secondary Policy: _____ Group # _____ ID # _____

Ins. Address: _____

Number for Precert: _____ Policy is in whose name? _____

Address of Policy Holder: _____ Relationship to Patient: _____

Date of Birth of Policy Holder: _____