PATIENT DATA TO BE COMPLETED IN FULL

Name_____ **Today's Date**_____

Social Security #_____**Date of Birth**_____

Marital Status ❑ Married ❑ Single ❑Widowed ❑ Divorced **Gender** ❑ Male ❑ Female

Home Address_____
Street City Zip code

Phone Numbers Home_____ Cell_____ Work_____

Primary Phone is ❑ Home ❑ Cell ❑Work

Email Address_____ **Preferred Contact Method** ❑ Phone ❑ Mail ❑ Email

Preferred Language ❑ English ❑ Polish ❑ Spanish ❑ Italian ❑ Other_____

Race ❑ American Indian/Alaskan Native ❑ Asian ❑ African American/ Black ❑ Caucasian/White ❑ Other_____

Ethnicity ❑ Hispanic or Latino ❑ Non-Hispanic or Latino

EMPLOYMENT

Employer_____ **Dept. | Title**_____

Employer's Address_____
Street City State Zip

Referred to Advanced GI by _____

Address_____
Street City State Zip

Primary Care Provider Name_____

Address_____
Street City State Zip

EMERGENCY CONTACT

Name & Relationship_____ **Daytime Phone**_____

Name & Relationship_____ **Daytime Phone**_____

PREFERRED PHARMACY INFORMATION

Pharmacy Name_____ **Pharmacy Phone**_____

Pharmacy Address_____
Street City State Zip

I authorize Advanced GI, LLC to obtain my prescription history electronically.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent to be treated by the staff and providers of Advanced GI, LLC. I authorize payment of medical benefits to Advanced GI, LLC and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient Signature_____ **Date**_____

Today' Date_____

Name_____ Age_____ Date of Birth_____

Referred by_____ Primary Care Physician_____

Describe the reason(s) for your visit_____

Medical History: Please check all that apply.

❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Blood Transfusion
❑ Cataracts
❑ Cirrhosis
❑ Colitis
❑ Colon Cancer
❑ Colon Polyps
❑ COPD
❑ Crohn's Disease
❑ Depression
❑ Diabetes
❑ Diverticulitis
❑ Diverticulosis
❑ Emphysema
❑ GERD/Heartburn
❑ Heart attack
❑ Glaucoma
❑ Hepatitis C
❑ Hiatal Hernia
❑ HIV/AIDS
❑ Hypertension
❑ Inflammatory Bowel Disease
❑ Kidney Disease
❑ Liver Disease
❑ Migraines
❑ Myocardial Infarction
❑ Osteoporosis
❑ Pancreatitis
❑ Stroke
❑ Thyroid Disease
❑ Tuberculosis
❑ Ulcers
❑ Seizure
Other:
_____

Are you currently on or have:

❑Dialysis-What dates are you scheduled for? _____
❑Pacemaker-When was the last cardiologist visit?_____
❑Heart Valve Replacement-When was the date of the procedure?_____
❑Heart Stents-When was the date of the procedure?_____
❑Oxygen at home
❑CHF-Congestive Heart Failure
❑AIED-Defibrillator

Have you ever had a Pneumococcal (Pneumonia) Vaccine? ❑ Yes ❑ No

Have you ever had any of the following vaccines? If so, please write down the dates the vaccines were given.

❑Influenza (Flu) ❑Hepatitis A ❑Hepatitis B ❑Other:_____

IMAGING/LABS

Check and provide dates if you have had any of the following laboratory tests and/or imaging services recently.

❑Amylase
❑CBC
❑Hepatitis Panel
❑Iron Studies
❑Lipase
❑Liver Panel
❑CT Scan
❑MRI
❑Ultrasound
❑X-ray
❑PT/PTT

SURGICAL HISTORY: Please check all that apply and state the date of surgery

❑Appendectomy
❑Brain Surgery
❑Breast Surgery
❑C-Section
❑CABG/Cardiac surgery
❑Colon Surgery_____
❑Colonoscopy_____
❑Gallbladder Surgery
❑Gastric Surgery
❑Hemorrhoid Surgery
❑Hernia Surgery
❑Hysterectomy
❑Liver Surgery
❑TIF/Nissen Fundoplication
❑Pacemaker_____
❑Prostate Surgery
❑Small Intestine Surgery
❑Spinal Surgery
❑Tonsillectomy
❑Tubal Ligation
❑Upper Endoscopy (EGD)____
❑Vasectomy
❑Other:_____

Name_____ **Date of Birth** _____

MEDICATIONS List Current Medications (including Herbal), Dosage and how often you take the medications

Are you currently taking any of the following blood thinners? ❑ Aggrenox ❑ Aspirin ❑ Brilinta ❑ Coumadin ❑ Eliquis ❑Heparin ❑Lovenox ❑ Plavix ❑ Pradaxa ❑ Xarelto ❑Other

Are you currently taking any of the following aspirin/NSAIDs? ❑ Advil ❑ Aleve ❑ Ibuprofen ❑ Naprosyn/Naproxen ❑ Other

ALLERGIES

List any medication allergies. ❑ No known medication allergies

_____

List any food allergies. ❑ No known food allergies

_____

List any environmental allergies. ❑ No known environmental allergies

_____

FAMILY HISTORY (BLOOD RELATIVE)

Colon Cancer ❑ Yes ❑ No Relation_____
Colon Polyps ❑ Yes ❑ No Relation_____
Crohn's Disease ❑ Yes ❑ No Relation_____
Liver Disease ❑ Yes ❑ No Relation_____
Ulcerative Colitis ❑ Yes ❑ No Relation_____
Do you or any family members have a history of Tuberculosis? ❑ Yes ❑ No_____

SOCIAL HISTORY

Provide details regarding current and/or past use of the following:
Alcohol (beer, wine, liquor) ❑ Yes ❑ No Usage_____
I.V. or Recreational Drugs ❑ Yes ❑ No Usage_____
Tobacco (cigarettes, cigars, chewing tobacco) ❑ Yes ❑ No Usage_____
If Yes, please indicate your age when you started: _____
Smoking Status ❑ Every Day ❑ Some Days ❑ Former Quit Date_____ ❑ Never

Patient Signature_____ Date_____