Referred By: ________________________________

Primary Care Physician: ________________________

Primary Care Physician Phone # __________________

NEW PATIENT INTAKE FORM

(Please note that all information is strictly confidential)

Patient Name: ___________________________________DOB: _________Age: _____Gender_____
(First) (Middle) (Last)

Social Security # __________-_________ -__________ Drivers License #:______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Address: ____
(Street) (City & State) (Zip Code)

Cell Phone #:___________________________ Home/Work Phone #___________________________

Pharmacy Name & Phone #:____

Patient Email Address: ____

Emergency Contact Name & Phone Number: ____

Reason for Today's Visit: ____

Date of last general physical exam: _______________

Our goal at Chicago Gastro is to offer you comprehensive medical care. If you have insurance coverage, we will make our best efforts to coordinate your care in a cost-effective manner within the limits of your insurance benefit. *I understand that I am financially responsible for all charges incurred for all treatment, including any co-payment, deductible, or remaining balance amount after payment of possible insurance benefits. I authorize the release of any medical information necessary to process any medical claims. I understand that if I have an HMO, it is my responsibility to obtain all referrals for services rendered with our physicians.*

CANCELLATION AND DELINQUENT ACCOUNT POLICY

In an effort to best serve the schedules of our patients: for office visits canceled less than 24 hours in advance, or failure to keep an appointment, patients will incur a $50 charge. For procedures canceled less than 72 hours in advance, or failure to keep a procedure appointment, patients will incur a $150 charge. All accounts not paid within 60 days will be forwarded to a Collections Agency and a 30% premium will be placed on all collections accounts.

I have read and understand the financial policy of this medical office and agree to be bound by its terms. I also understand and agree that such terms maybe amended by the practice without prior written notice.

____

Signature of Patient or Legal Guardian **Printed Name** **Date**

Employer:____

Primary Insurance Company Name: _____________________ Policy #:___________________

Insured Name: _________________ Insured SS#______________ Group #: _______________

Secondary Insurance Company Name: ___________________ Policy #: ___________________

May we discuss test results with a family member/friend? ________ Who? __________________

May we leave test results on your voicemail? _____________

History of Present Illness

Location of Discomfort:____

Severity:____
(how severe is the discomfort on a scale of 1-10, where 10 is the worst pain)

Duration: ____
(how long have you had this problem – weeks, months, years)

Modifying factors:____
(what makes your symptoms better/worse)

Please Circle Any Gastrointestinal Medications you have taken within the past month:

Aspirin containing medications: Excedrin, Aspirin, Alka-Seltzer ....
Arthritis medications: Nsaids, Motrin, Ibuprofen, Advil, Aleve ....
Ulcer medications: Prilosec, Prevacid, Aciphex, Tagamet, Protonix, Nexium ....
Stomach cramp medications: Librax, Levsin, Hyoscyamine, Bentyl NuLev, Zelnorm.....
Nerve pills: Xanax, Valium, Prozac, Zoloft, Paxil ....
Blood thinners: Coumadin, Aspirin, Heparin, etc...
Anti nausea medications: Phenergan, Zofran, Compazine ....
Laxatives: Correctol, Senokot, Lactulose, Miralax...
Herbal Products ______________________________ ....
Gastric emptying pills: Reglan, Propulsid...
Fiber supplements: Metamucil, Fiber-Con, Citrucel, Konsyl...
Diet pills: Prescription or over-the-counter_________________________________ ......
Cholesterol medications: Questran powder, Cholestid, Welchol ....
Diarrhea medications: Imodium, Lomotil Pepto Bismol..
Colon medications: Asacol, Pentasa, Prednisone, Imuran, Purinethol, Methotrexate, Remicade

Medications: (Include over the counter and herbal products)

Name	Dose /Frequency	Condition Being Treated

Allergies (medications, foods)

____

Medical History

Arthritis/Gout .... No Yes
Bleeding Tendency .... No Yes
Breathing Problems .... No Yes
Cancer .... No Yes
Diabetes .... No Yes
Heart Failure/Heart Attack................ No Yes
HIV .... No Yes
Hypertension................................... No Yes
Seizures.. No Yes
Stress/Anxiety.................................. No Yes
Stroke .... No Yes
Venereal Disease............................. No Yes

Additional Medical Problems:

____

____

____

Previous Hospitalizations/Surgeries/Serious Injuries:

____

____

Social History

Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Tobacco Use: ☐ Never ☐ Previously, but quit Current packs/day__________
Caffeine Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Drug Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily Drugs used:__________________

Family Medical History

Please list any gastrointestinal problems in your family (parents, siblings, grandparents). Examples include stomach/colon/liver problems; polyps, crohns, ulcerative colitis; breast/ovarian/colon/stomach/ liver cancer/ulcer disease

____

____

____

____

____

Have you ever had any of the following studies? (please check):

		Where	Results	Date
Barium enema	☐ Yes ☐ No	____________________	________________________	__________
Colonoscopy	☐ Yes ☐ No	____________________	________________________	__________
Upper GI	☐ Yes ☐ No	____________________	________________________	__________
Ultrasound of gallbladder	☐ Yes ☐ No	____________________	________________________	__________
CT of abdomen	☐ Yes ☐ No	____________________	________________________	__________
Hida Scan	☐ Yes ☐ No	____________________	________________________	__________
Gastric emptying scan	☐ Yes ☐ No	____________________	________________________	__________
Endoscopy (stomach)	☐ Yes ☐ No	____________________	________________________	__________
Flexible Sigmoidoscopy	☐ Yes ☐ No	____________________	________________________	__________
ERCP	☐ ☐es No	____________________	________________________	__________

Current Symptoms

Gastrointestinal - Upper
Abdominal Pain .... No Yes
Acid Reflux/GERD .... No Yes
Black Stool .... No Yes
Excessive Belching .... No Yes
Food Sticking .... No Yes
Heartburn .... No Yes
Indigestion .... No Yes
Loss of Appetite .... No Yes
Nausea/Vomiting .... No Yes
Painful Swallowing .... No Yes
Vomiting Blood .... No Yes
Weight Loss .... No Yes

Gastrointestinal - Lower
Blood in Stool/Rectal Bleeding .... No Yes
Bowel Movement Urgency .... No Yes
Change in Bowel Habits .... No Yes
Constipation .... No Yes
Diarrhea .... No Yes
Fecal Soiling .... No Yes
Gas/Bloating .... No Yes
Hemorrhoids .... No Yes
Painful Bowel Movements .... No Yes
Rectal Pain .... No Yes

Cardiovascular
Chest Pain .... No Yes
Palpitations .... No Yes
Swelling Feet or Ankles .... No Yes

Constitutional Symptoms
Fever .... No Yes
Fatigue .... No Yes
Headaches .... No Yes
Recent Weight Change .... No Yes

Eyes
Blurred or Double Vision .... No Yes
Eye Disease or Eye Injury .... No Yes
Glasses/Contacts .... No Yes

Ears/Nose/Mouth/Throat
Bad Breath/Taste .... No Yes
Chronic Sinus/Rhinitis .... No Yes
Earaches .... No Yes
Hearing Loss/Ringing .... No Yes
Mouth Sores .... No Yes
Nose Bleeds .... No Yes
Sore Throat/Voice Change .... No Yes

Respiratory
Asthma/Wheezing .... No Yes
Chronic Cough .... No Yes
Shortness of Breath .... No Yes
Spitting-Up Blood .... No Yes

Allergies
Aspirin/Pain Medication .... No Yes
Iodine .... No Yes
Morphine/Narcotics .... No Yes
Novocain/Anesthetics .... No Yes
Penicillin/Antibiotics .... No Yes
Other drugs____________________ ... No Yes
Food allergies____________________ No Yes

Endocrine
Cold/Heat intolerance .... No Yes
Diabetes .... No Yes
Dry Skin .... No Yes
Excessive Thirst .... No Yes
Palpitations .... No Yes

Hematologic
Anemia .... No Yes
Bleeding/bruising .... No Yes
Enlarged glands .... No Yes
Past Transfusion .... No Yes
Slow to heal after cuts .... No Yes

Musculoskeletal
Back Pain .... No Yes
Cold Extremities .... No Yes
Difficulty Walking .... No Yes
Joint Stiffness/Swelling .... No Yes
Muscle Pain/Cramps .... No Yes
Weakness of Muscles/Joints .... No Yes

Neurological
Dizziness .... No Yes
Frequent headaches .... No Yes
Head injury .... No Yes
Paralysis .... No Yes
Seizures or Convulsions .... No Yes
Stroke .... No Yes
Tingling or Numbness .... No Yes
Tremors .... No Yes

Psychiatric
Anxiety .... No Yes
Depression .... No Yes
Insomnia .... No Yes
Memory loss/confusion .... No Yes
Nervousness .... No Yes

Genitourinary
Blood in Urine .... No Yes
Burning/Painful Urination .... No Yes
Frequent Urination .... No Yes
Kidney Stones .... No Yes
Incontinence/Dribbling .... No Yes
Male-Testicle Pain .... No Yes
Sexual Difficulty .... No Yes