



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)

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Emergency Contact Name & Phone Number: _____

Email Address: _____ Pharmacy Phone #: _____

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 #: _____

Insured Name: _____ Group #: _____

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:

- 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 <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | _____ |
| Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | _____ |
| Upper GI <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | _____ |
| Ultrasound of gallbladder <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | _____ |
| CT of abdomen <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | _____ |
| Hida Scan <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | _____ |
| Gastric emptying scan <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | _____ |
| Endoscopy (stomach) <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | _____ |
| Flexible Sigmoidoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | _____ |
| ERCP <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ | _____ |



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