GREAT LAKES GASTROENTEROLOGY/ONE GI

8877 MENTOR AVE, MENTOR, OH 44060 PHONE: 440-205-1225

PATIENT INFORMATION

Last Name:			Primary Physician:
First Name:		Middle Initial:	Referring Physician:
Address:		Apt:	Date of Birth:
City:	State:	Zip Code:	Marital Status: (Circle One) Single/ Married/ Divorced/ Widowed
Home Phone ( )	Cell Phone ( )	(Please circle preferred)	Social Security #:
Work Phone:	Ext:		Employer:

EMERGENCY CONTACT

Name:	Relationship:
Home/Cell Phone:	Consent for Communication: (Circle One) Yes / No

GENERAL INFORMATION:

Consent to patients Rx History: (Circle One) Yes / No	Living Will DPOA Guardianship None (Circle All That Apply)
Email Address:	May we leave you voicemails: (Circle One) Yes / No May we communicate through SMS (text) Yes / No

PHARMACY INFORMATION:

Local Pharmacy/City/Phone Number:

Mail Order Pharmacy:

PRIMARY INSURANCE INFORMATION:

Primary Insurance Name:

Subscriber's Name:	Subscriber's ID#	Subscriber's DOB:
Relationship to Patient:		Copay Amount: $

SECONDARY INSURANCE INFORMATION:

Secondary Insurance Name:

Subscriber's Name:	Subscriber's ID#	Subscriber's DOB:
Relationship to Patient:		Copay Amount: $

VOLUNTEER INFORMATION FOR GOVERNMENT REPORTING:

Race: White African American Other Race _____ Language: English Spanish Other _____

Ethnicity: Hispanic or Latin Not Hispanic or Latin Refuse to Report

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. It is my responsibility to pay any copays, deductibles or any other balance not paid for by my insurance. If a referral is needed for insurance, it is my responsibility to get that referral from my PCP.
2. I authorize the release of all medical information to process claims for medical care received.
3. I am aware of the (HIPAA) Privacy Act and I understand I have the right to have a copy furnished to me upon request.
4. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment
5. Patient rights and responsibilities: A copy of your rights and responsibilities are posted and a copy is available upon request.

SIGNATURE

Patient Signature:	Date:

GREAT LAKES GASTROENTEROLOGY powered by OneGI

THE ENDOSCOPY CENTER OF LAKE COUNTY

Medical History

Name *(First, Middle, Last)* _____ **Today's Date**

Date of Birth _____

Medical History

Medical History – Please check any of the medical conditions for which you have seen a doctor.

- ❑ None
- ❑ Anemia
- ❑ Anxiety Disorder
- Arthritis
  - ❑ Osteoarthritis
  - ❑ Rheumatoid
- ❑ Asthma
- Cancer
  - ❑ Breast
  - ❑ Colon
  - ❑ Esophageal
  - ❑ Kidney
  - ❑ Liver
  - ❑ Lung
  - ❑ Ovarian
  - ❑ Prostate
  - ❑ Stomach
  - ❑ Uterine
  - ❑ Skin:
  - ❑ Other_____
- ❑ Celiac Sprue
- ❑ Colon Polyp
- ❑ Congestive Heart Failure
- ❑ COPD
- ❑ coronary artery disease
- ❑ Crohn's Disease
- ❑ Dementia
- ❑ Alzheimer's
- ❑ Depression
- ❑ Diabetes
- Diverticular Disease
  - ❑ Diverticulitis
  - ❑ Diverticulosis
- ❑ Emphysema
- Esophageal Disease
  - ❑ Barret's Esophagus
  - ❑ Varices
- ❑ Fibromyalgia
- ❑ Gallstones
- ❑ Glaucoma
- ❑ Headache, migraine
- Heart Arrhythmias
  - ❑ Atrial Fibrillation
  - ❑ Tachycardia
  - ❑ Bradycardia
  - ❑ SVT
- ❑ Heart Attack ____(mm/yyyy)
- ❑ heart valve disease
- ❑ Hemorrhoids
- Hepatitis/Liver Disease
  - ❑ Cirrhosis
  - ❑ Hepatitis A
  - ❑ Hepatitis B
  - ❑ Hepatitis C
  - ❑ Hepatitis Other _____
  - ❑ Jaundice
  - ❑ Fatty Liver
- ❑ Hiatal Hernia
- ❑ High Blood Pressure
- ❑ High Cholesterol (lipids)
- ❑ HIV
- ❑ irritable bowel syndrome
- ❑ Kidney/Renal Disease
- ❑ Kidney Stones
- ❑ Pancreatitis
- ❑ Parkinson's Disease
- ❑ Reflux (GERD)
- ❑ Seizure disorder
- ❑ Sjogren's Disease
- ❑ Sleep Apnea/CPAP
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Ulcerative Colitis
- ❑ Other *(please list):*

Home oxygen use:
❑Day ❑Night Liters: _____

Specialist:
- ❑ Cardiologist_____
- ❑ Pulmonologist_____
- ❑Nephrologist_____

Surgical History

Surgical History – Please check any of the surgeries that you have had

- ❑ Check if None
- ❑ Appendix Removal
- ❑ Back Surgery
- ❑ Blood Transfusions
- Colon Surgery:
  - ❑ Colectomy
  - ❑ Partial Colectomy
  - ❑ Colostomy
  - ❑ Ileostomy
- ❑ C-Section
- Feeding tube:
  - ❑ G tube
  - ❑ J tube
- ❑ Gallbladder Surgery
- Gastric Bypass/ Weight Loss Surgery:
  - ❑ Duodenal Switch
  - ❑ Gastric Sleeve
  - ❑ Roux en Y
- ❑ Heart Stents _____(mm/yyyy)
- ❑ Heart Surgery/Bypass_____(mm/yyyy)
- ❑ Heart Valve Replacement, Aortic
- ❑ Heart Valve Replacement, Mitral
- ❑ Hernia Repair
- ❑ Hiatal Hernia Surgery
- ❑ Hysterectomy
- ❑ ICD (Internal Cardiac Defibrillator)
- Joint Replacement/Joint Surgery
  - ❑ Hip replacement
  - ❑ Knee replacement
  - ❑ Shoulder replacement
  - ❑ Joint Surgery
- ❑ Laparoscopy (abdominal)
- ❑ Liver Biopsy
- ❑ Lung Surgery
- ❑ Mastectomy (Breast) Surgery
- ❑ MOH (skin cancer procedure)
- ❑ Pacemaker (date last checked_____)
- ❑ Prostate
- ❑ Small bowel resection
- Throat/Mouth Surgery
  - ❑ Tonsillectomy
  - ❑ Adenoidectomy
  - ❑ Wisdom Teeth
  - ❑ Other _____
- ❑ Thyroidectomy
- ❑ Transplant
- ❑Any Anesthesia issues? _____
- ❑History of difficult intubation? _____
- ❑Metal or plastic implants? If yes where: _____

Social History

Are you:
❑ Single ❑ Married ❑ Widowed
❑ Partner ❑ Divorced/Separated
Children ❑ yes ❑ no how many_____

Do you use tobacco?
❑ No
❑ Quit *(year)* _____ age started ____ age stopped ____
❑ Yes type _____
# of years ____ packs per day_____

Do you consume alcoholic drinks? ❑ No ❑ Yes ❑ Quit *(year)* _____
Type _____
Frequency/Amount _____

Do you drink/consume caffeine? ❑ No ❑ Yes
Type _____
Amount per day _____

Do you currently use recreational drugs? ❑ No ❑ Yes
Type_____ Frequency_____

Name: **DOB:**

Family Medical History – If yes, list Relation and Age: ☐ Check If None

Colon Cancer	No	Yes	
Colon Polyps	No	Yes	
Inflammatory Bowel Disease	No	Yes	
Cancer of:			
Endometrial	No	Yes	
Esophagus	No	Yes	
Kidney	No	Yes	
Ovarian	No	Yes	
Pancreas	No	Yes	
Small Bowel	No	Yes	
Stomach	No	Yes	

MEDICATIONS

Current Medications – List ALL, Prescription, Supplements, and Over the counter Medications ☐ Check If None

Medication Name:	Dose and Frequency:	Reason for taking:

Allergies, Sensitivities, Reactions: ☐ Check If None

Date form received

Initials of reviewer

Name: _____ **DOB:** _____

REVIEW OF SYSTEMS

Are you having any of the following symptoms:

Gastrointestinal		
Nausea	No	Yes
Vomiting	No	Yes
Heartburn	No	Yes
Food sticking in throat	No	Yes
Painful swallowing	No	Yes
Vomiting blood	No	Yes
Black stool	No	Yes
Red blood in stool	No	Yes
Abdominal pain	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Loss of appetite	No	Yes
Early satiety	No	Yes
Bloating	No	Yes
Hemorrhoids	No	Yes

Constitutional		
Recent weight gain # of pounds____	No	Yes
Recent weight loss # of pounds ____	No	Yes

HEENT		
Sore throat	No	Yes
Hoarseness	No	Yes

Cardiovascular		
Abnormal heart rhythm	No	Yes
Chest pain	No	Yes
Palpitations	No	Yes

Respiratory		
Cough	No	Yes
Shortness of breath on exertion	No	Yes
Shortness of breath at rest	No	Yes
Wheezing	No	Yes

Genitourinary		
Frequent urination	No	Yes
Kidney failure/dialysis	No	Yes
Painful urination	No	Yes

Neurological		
Seizures	No	Yes
Headaches	No	Yes

Dermatology		
Rash	No	Yes

Musculoskeletal		
Joint Pain	No	Yes
Arthritis	No	Yes

Psychiatric		
Dementia	No	Yes
Depression	No	Yes
Anxiety	No	Yes

Height:_____
Weight:_____

Have you had a previous colonoscopy? No Yes (mm/yyyy)_____
Have you had a previous EGD? No Yes (mm/yyyy)_____

Authorization:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: _____ Date: _____

Date form received

Initials of reviewer