NORTON GASTROENTEROLOGY CONSULTANTS OF LOUISVILLE

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GASTROENTEROLOGY HEPATOLOGY DIAGNOSTIC & THERAPEUTIC ENDOSCOPY

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Dear Patient:

You have an appointment with one of the physicians in our office. Please arrive 30 minutes prior to your scheduled appointment time. We ask you to complete the attached paperwork and either fax (502-896-4791) or bring with you to your appointment as an effort to help with the process of your visit. In addition to the paperwork, below is a list of items which are also required.

1. Any recent lab/blood work results from your primary care/referring physician.
2. Any CT, MRI, ultrasound, Hida scans, EGD and colonoscopy reports.
3. Any medical records from your primary care/referring physician.
4. A referral/authorization from your insurance company, if one is required.
5. Insurance cards and picture ID (driver's license).
6. Your co-pay will be due at the time of your visit, as well as any outstanding balance on your account.

We look forward to helping you with your patient care needs. Should you have any questions, please contact our office (502-896-4711) and we will be glad to assist you.

Thank you,

Norton Gastroenterology Consultants of Louisville

PATIENT INFORMATION FORM – PLEASE PRINT

Name (first, mi, last): _____ Age: _____ Sex: Male / Female

Date of Birth: _____ Social Security No: _____ Marital Status: _____

Address: _____

Home No: _____ Work No: _____ Mobile No: _____

Patient's Employer/Address: _____

Spouse's Name: _____ Mobile No: _____

Emergency Contact /Relationship: _____ Phone No: _____

Primary Care/Referring Physician Name/Number: _____

Pharmacy Name: _____ Pharmacy Phone No: _____

PRIMARY INSURANCE COVERAGE

Subscribers Name: _____ Date of Birth: _____

Subscribers Social Security No: _____ Relationship to Patient: _____

Insurance Company: _____

Insurance Address: _____

Policy No: _____ Group No: _____

Subscribers Employer/Address: _____

SECONDARY INSURANCE COVERAGE

Subscribers Name: _____ Date of Birth: _____

Subscribers Social Security No: _____ Relationship to Patient: _____

Insurance Company: _____

Insurance Address: _____

Policy No: _____ Group No: _____

Subscribers Employer/Address: _____

PAST MEDICAL HISTORY: (e.g.: high blood pressure, diabetes, heart disease, other):

_____

_____

_____

_____

_____

PREVIOUS SURGERIES

Type of surgery	Date	Name of Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had joint replacement? _____ Which joint? _____ When? _____

Surgeon's Name: _____

Have you had heart surgery/valve replacement or heart stenting? _____ When? _____

Cardiologist's Name: _____

Do you have a pacemaker/defibrillator? _____

Other Previous Surgeries and name of surgeons: _____

_____

_____

MEDICATIONS

Please circle any of the following medications you are currently taking.

Coumadin/Warfarin/Jantoven Pradaxa/Dabigatran Xarelto/Rivaroxaban Plavix/Clopidogrel

Effient/Prasugrel Lovenox/Enoxaparin Arixtra/Fondaparinux Brilinta/Ticagrelor Fragmin

Eliquis/Apixaban Aggrenox/ASA with Dipyridamole Ticlid/Ticlodipine Persantine/Dipyridamole

Physician who manages blood thinner: _____

Name of Other Medications (or attach list)	Dose	Name of Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

List allergies to medications and type of reaction:

_____

_____

_____

_____

_____

Are you allergic to latex? _____

SOCIAL HISTORY

Marital status (please circle): Single Married Divorced Widow/Widower

Who lives with you? _____

Education (please circle): High School Some College College Postgraduate

What type of work do you perform? _____

Do you smoke? _____ Packs per day: _____ How many years? _____

Did you smoke in the past? _____

Do you drink alcohol? _____ Did you drink in the past? _____

How many drinks per day? _____ Drinks per week: _____ Drinks per month: _____

FAMILY HISTORY

Do you have any family members with colon cancer? _____

If yes, who and what age diagnosed: _____

Do you have any family members with colon polyps? _____

If yes, who and what age diagnosed: _____

Do you have any family members with other cancers (uterus, ovary, other)? _____

Other significant family history: _____

_____

_____

GASTROINTESTINAL HISTORY

Have you had a sigmoidoscopy? _____ When? _____ When was your last EGD? _____

Have you had a colonoscopy? _____ When? _____ Findings: _____

Do you have history of Barrett's Esophagus? _____

Do you have liver disease? _____ Ulcerative Colitis? _____ Crohn's Disease? _____

Other gastrointestinal diseases? _____

_____

REVIEW OF SYSTEMS (Do you have any of the following symptoms):

Allergic/Immunologic

Allergies (Non Meds)	Yes / No
Frequent Infections	Yes / No
HIV/AIDS	Yes / No
Other _____	

Constitution

Activity Change	Yes / No
Weight Gain	Yes / No
Unintentional Weight Loss	Yes / No
Fever	Yes / No
Fatigue	Yes / No
Weakness	Yes / No
Other _____	

Ears

Hearing Loss	Yes / No
Ringing In Ears	Yes / No
Other _____	

Gynecology (if applicable)

Last Menstrual Period	Yes / No
Post Menopausal	Yes / No
Uterine Cancer	Yes / No
Cervical Cancer	Yes / No
Other _____	

Heart

Ankle Swelling	Yes / No
Artificial Valve	Yes / No
Chest Pain	Yes / No
Heart Murmurs	Yes / No
High Blood Pressure	Yes / No
History of Heart Attack	Yes / No
Mitral Valve Prolapse	Yes / No
Pacemaker	Yes / No
Defibrillator	Yes / No
Palpitations	Yes / No
Other _____	

REVIEW OF SYSTEMS continued (Do you have any of the following symptoms):

Mouth
Ulcers Yes / No
Sores Yes / No
Other _____

Nose
Sinus Trouble Yes / No
Nose Bleeds Yes / No
Other _____

Throat
Sore Throat Yes / No
Other _____

Eyes
Blurred Vision Yes / No
Loss of Sight Yes / No
Other _____

Lungs
Asthma Yes / No
Cough Yes / No
Shortness of Breath Yes / No
Emphysema Yes / No
Wheezing Yes / No
Sleep Apnea Yes / No
Other _____

Skin
Rash Yes / No
Itching Yes / No
Jaundice (yellow eyes or skin) Yes / No
Other _____

Neurological
Dizziness Yes / No
Seizure Disorder Yes / No
Epilepsy Yes / No
Other _____

Musculoskeletal
Arthritis Yes / No
Back Pain Yes / No
Joint Pain Yes / No
Other _____

Infectious Disease
Have You Had Tuberculosis Yes / No
Have you Had Histoplasmosis Yes / No

Gastrointestinal
Difficulty Swallowing Yes / No
Heartburn Yes / No
Hiatal Hernia Yes / No
Indigestion Yes / No
Nausea Yes / No
Vomiting Yes / No
Black Tarry Stools Yes / No
Abdominal Pain Yes / No
Belching/Gaseousness Yes / No
Bloating Yes / No
Constipation Yes / No
Diarrhea Yes / No
Frequent Laxative Use Yes / No
Hemorrhoids Yes / No
Rectal Bleeding Yes / No
Hepatitis Yes / No
Liver Disease Yes / No
Gallstones Yes / No
Inguinal Hernia Yes / No
Other _____

Urinary
Difficulty Urinating Yes / No
Blood in Urine Yes / No
Frequent Urination Yes / No
Tract Infections Yes / No
Kidney Stones Yes / No
Other _____

Hematologic/Lymphatic
Abnormal Post Surgical Bleeding Yes / No
Anemia Yes / No
Easy Bruising/Bleeding Yes / No
Other _____

Endocrine
Diabetes Yes / No
Thyroid Disease Yes / No
Other _____

Psychiatric
Agitation Yes / No
Anxiety Yes / No
Confusion Yes / No
Nervous Yes / No
Depression Yes / No
Trouble Sleeping Yes / No
Other _____