Advanced Gastroenterology PLLC
Advanced Endoscopy Center PLLC

PATIENT REGISTRATION

Please print and fill out ALL information below.

Name (First, MI, Last): _____ **Gender: ☐ Male ☐ Female**
Address: _____Apt:_____ **Date of Birth:_____**
City, State, Zip: _____ **SSN #: _____**

Primary Phone: (____)_____Type:_____ **Okay to leave a message Y / N**
Secondary Phone: (____)_____ Type:_____ **Okay to leave a message Y / N**

Please list your preferred email below:
Email: _____
Primary Care Doctor: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Ethnicity or Race:
□ Hispanic □ American Indian/Alaska Native
□ Native Hawaiian/Other Pacific Islander
□ Asian □ Black/African American □ Caucasian

Patient Employment Information

☐ Employed ☐ Unemployed ☐ Other ☐ Retired *Estimated Date of Retirement:_____
Employer / Company Name: _____
Employer's Phone: (____)_____

Insurance Information (If you are insured **through someone else**, please list their information below)

Primary Ins: _____
ID #: _____
Group/Policy #: _____
***Subscriber's Name**: _____
***Subscriber's DOB**: _____
Relationship to Patient: _____

Secondary Ins: _____
ID # _____
Group/Policy #: _____
***Subscriber's Name**: _____
***Subscriber's DOB**: _____
Relationship to Patient: _____

Please list below whom you Authorize us to contact in case of an emergency or regarding your Medical and Billing information. *(Please list at least **ONE** contact)*

Name: _____ Phone: (____)_____Relationship to Patient:_____
Name: _____ Phone: (____)_____Relationship to Patient:_____

How did you hear about our office? _____

I attest that the information I have given here is correct and true to the best of my knowledge. I understand that I am responsible for keeping the doctor updated with current information regarding my account.

_____ _____
Patient/Guardian Signature Date

HEALTH HISTORY

Name: _____ DOB: _____ Date: _____
Please Print

REASON FOR VISIT: _____

PRIMARY CARE DOCTOR: _____ □ **NO Primary Care Provider**

Medical Problems:

□ Anemia	□ Colon cancer	□ Heartburn	□ Kidney stones	□ Thyroid problems
□ Anxiety	□ Colon polyps	□ Hepatitis – Type_____	□ Osteoporosis	□ Sleep Apnea
□ Arthritis	□ Crohn's disease	□ Hiatal hernia	□ Pancreatitis	□ **Other:** _____
□ Asthma	□ Depression	□ High blood pressure	□ Parkinson's disease	
□ Cataracts	□ Diabetes	□ High cholesterol	□ Rheumatic fever	
□ Chronic cough	□ Diverticulosis	□ Irregular heartbeat	□ Seizure	
□ Chronic lung disease	□ Fibromyalgia	□ Irritable bowel syndrome	□ Stomach/duodenal ulcer	
□ Cirrhosis of liver	□ Gallstones	□ Kidney disease/failure	□ Stroke/paralysis	

Surgeries/Procedures:

□ ***NONE***	□ *Endoscopy (EGD)*–Date: _____	□ Liver biopsy
□ Appendectomy	□ Esophageal Manometry/pH study	□ Obesity surgery
□ Breast surgery-TYPE: _____	□ Flexible Sigmoidoscopy–Date: _____	□ Prostate
□ Cardiac surgery	□ Gallbladder surgery	□ Stomach
□ Colon resection	□ Hiatal hernia surgery	□ Thyroidectomy
□ Colostomy	□ Hemorrhoidectomy	□ Tonsillectomy
□ C-Section	□ Hysterectomy	□ Tubal ligation
□ *Colonoscopy*–Date: _____	□ Joint replacement	□ **Other Surgery:** _____
Location: _____		

Social History:

Marital Status: □ Single □ Married □ Divorced □ Widow

Current Occupation: _____ □ Unemployed Employer: _____

Do you currently smoke? □ Yes □ No How many packs per day? _____

If you've smoked previously, when did you stop? _____ For how many years did you smoke? _____

Do you drink alcohol? □ Yes □ No How many drinks per day? _____ per week? _____ per month? _____

Do you use drugs (including marijuana)? □ Yes □ No If yes, what kind? _____

Family History:

History of Heart Disease (heart attack, heart failure)? □ Yes □ No who: _____

History of Strokes? □ Yes □ No who: _____

History of High blood pressure? □ Yes □ No who: _____

History of Diabetes? □ Yes □ No who: _____

History of Cancer? □ Yes □ No who: _____ Type: _____

History of Crohn's disease or Ulcerative Colitis? □ Yes □ No who: _____

Other: _____

(OVER)

Medications- Please list only your *current* medications or provide a list if you have one:

□ ***NOT CURRENTLY TAKING ANY MEDICATIONS***

	Name	Strength (mg, mcg)	Times per day
1.			
2.			
3.			
4.			
5.			

***PLEASE LIST YOUR PREFERRED PHARMACY/LOCATION:** _____

ARE YOU TAKING ANY ANTICOAGULATION MEDICATIONS? □ **YES** □ **NO**

Allergies: Aspirin Morphine Penicillin Sulfa Versed Valium ***NONE*** Other: _____

Review of Systems- Please indicate if you are ***currently*** experiencing the following:

General: □ appetite change, □ chills, □ diaphoresis (sweats), □ fatigue, □ fever, □ weight loss, □ NONE

Ears/Nose/Throat: □ congestion, □ ear pain, □ hearing loss, □ nosebleeds, □ sore throat, □trouble swallowing, □ NONE

Eyes: □ eye itching, □ eye pain, □ eye redness, □ visual disturbance, □ NONE

Respiratory: □ apnea, □ chest tightness, □ choking, □ cough, □ shortness of breath, □ wheezing, □ NONE

Cardiovascular: □ chest pain, □ leg swelling, □ palpitations, □ NONE

Gastrointestinal: □ abdominal distention, □ abdominal pain, □ blood in stool, □ constipation, □ diarrhea, □ nausea, □ rectal pain, □ vomiting, □ NONE

Endocrine: □ cold intolerance, □ heat intolerance, □ polydipsia (excessive thirst), □ polyphagia (excessive hunger), □ polyuria (excessive urination), □ NONE

Genitourinary: □ difficulty urinating, □ dysuria (painful urination), □ frequency, □ genital sore, □ hematuria (bloody urination), □ menstrual problem, □ pelvic pain, □ urgency, □ NONE

Musculoskeletal: □ arthralgias (joint pain), □ back pain, □ joint swelling, □ myalgias (muscle pain), □ neck pain, □ neck stiffness, □ NONE

Skin: □ color change, □ pallor (paleness), □ rash, □ wound, □ NONE

Allergic/Immunologic: □ environmental allergies, □ food allergies, □ immunocompromised, □ NONE

Neurologic: □ dizziness, □ headaches, □ numbness, □ seizures, □ syncope (passing out), □ tremors, □ weakness, □ NONE

Heme/Lymphatic: □ adenopathy (enlarged lymph nodes), □ bruises/bleeds easily, □ NONE

Psychiatric: □ confusion, □ decreased concentration, □ dysphoric mood, □ hallucinations, □ hyperactive, □ nervous/anxious, □ sleep disturbance, □ suicidal ideas, □ NONE

I authorize Advanced Gastroenterology to communicate with and obtain medication history from my pharmacy.

Patient Signature: _____ Date: _____