INDIANAPOLIS GASTROENTEROLOGY
PATIENT INFORMATION

PATIENT INFO

Date:_______________ Patient: ____
(Last) (First) (Middle)

Date of Birth:__________________ Social Security Number: ________________ Marital Status:____________

Address: ______________________________ City:____________________ State:________ Zip: ____________

Home Number:________________ Work Number: ________________ Cell Phone Number:______________
(We are unable to return calls to pagers)

Place of Employment: (If retired, from where) ____________________ Occupation ______________________

Spouse's Name:____ Date of Birth: ______________________

Primary Care Physician:_______________________ Primary Care Physician Phone:______________________

Referring Physician:___________________________ Referring Physician Phone:_________________________

Name and phone number of nearest relative and relationship not living with you: _________________________

____

PRIMARY INSURANCE

Group #:______________________

Policy Holder Name:____ Acct #_________________________
(Last) (First) (Middle)

Date of Birth:__________________________ Social Security Number: ____________________________________

Address: ____

City:_______________________________________ State:____________________ Zip: ____________________

Home Number:_____________________________________ Work Number:______________________________

Employer: ____

SECONDARY INSURANCE

Group #:______________________

Policy Holder Name:____ Acct #_________________________
(Last) (First) (Middle)

Date of Birth:__________________________ Social Security Number: ____________________________________

Address: ____

City:_______________________________________ State:____________________ Zip: ____________________

Home Number:_____________________________________ Work Number:______________________________

Employer: ____

FOR MINORS (UNDER 18 YEARS OF AGE):

Parent's Name: ____
(Last) (First) (Middle)

Address: ____

City:_______________________________________ State:____________________ Zip: ____________________

Home Number:____________________________________ Work Number: _____________________________

THE FOLLOWING IS APPLICABLE TO MEDICARE PATIENTS ONLY!

Is the Medicare patient under the Legal Guardianship of a third party or has the Medicare patient granted Power of Attorney to any third party?

Yes______ No ______ If your answer is yes, please provide the following information:

Name of Legal Representative:____

Address: ____

City:_______________________________________ State:____________________ Zip: ____________________

Phone Number:______________________________________

This information is necessary for Medicare Electronic Claim Filing.

PLEASE COMPLETE THE MEDICAL HISTORY ON THE REVERSE SIDE OF THIS FORM.

198-3

Indianapolis Gastroenterology
Adult Historical Summary

Name_______________________________ **Date of Birth**___________ **Sex: M F**

MEDICAL HISTORY

(check any past or current problems)

☐ skin
☐ headache
☐ eyes
☐ ears
☐ nose
☐ mouth
☐ loose / chipped teeth
☐ throat
☐ pain ____________ ____________
☐ hoarseness
☐ heartburn
☐ swallowing
☐ stomach
☐ ulcer
☐ vomiting
☐ weight loss
☐ liver / hepatitis
☐ gallbladder
☐ cancer location ____________ ____________
☐ small intestine / colon
☐ constipation
☐ diarrhea
☐ kidney / urinary bladder
☐ uterus / ovaries / testicles
☐ bleeding
☐ high blood pressure
☐ stroke
☐ heart
☐ circulation
☐ seizures
☐ lungs
☐ asthma
☐ arthritis / joint problems
☐ chronic cough
☐ tuberculosis
☐ diabetes
☐ bones
☐ other __________________ __________________

☐ problems with anesthesia, describe ____

List any previous illnesses / hospitalizations / surgeries / procedures:____________________________________
____
____
____

List any drug allergies ____
____

Give approximate date of your last: Pneumonia Shot ____ Flu Shot ____ Tetanus Shot ____ TB Skin Test ____

Breast Exam by MD ____ Mammogram ____ Pap Smear ____ Stool Check For Blood ____

Rectal Exam of Prostate ____ Prostate Cancer Blood Test ____ Cholesterol Test ____

MEDICATION LIST

Please bring a complete list of all medications and dosages including over the counter medications.

1__________________ 2 __________________ 3 __________________ 4 __________________ 5 __________________
6__________________ 7 __________________ 8 __________________ 9 __________________ 10 __________________

FAMILY HISTORY

Father: ☐ living ☐ dead age at death (if applicable)______ cause of death (if applicable)____________________________
Mother: ☐ living ☐ dead age at death (if applicable)______ cause of death (if applicable)____________________________

	Father	Mother	Children	Brothers/ Sisters	Grandparents
esophagus disease	☐	☐	☐	☐	☐
ulcerative colitis	☐	☐	☐	☐	☐
Crohn’s disease	☐	☐	☐	☐	☐
lung disease	☐	☐	☐	☐	☐
heart disease	☐	☐	☐	☐	☐
kidney disease	☐	☐	☐	☐	☐
pancreas disease	☐	☐	☐	☐	☐

	Father	Mother	Children	Brothers/ Sisters	Grandparents
bleeding disorder	☐	☐	☐	☐	☐
colon polyps	☐	☐	☐	☐	☐
colon cancer	☐	☐	☐	☐	☐
cancer - not colon	☐	☐	☐	☐	☐
ulcer disease	☐	☐	☐	☐	☐
liver disease	☐	☐	☐	☐	☐
gallstones	☐	☐	☐	☐	☐

Do you have an advance directive? ☐ Yes ☐ No If yes, ☐ living will ☐ durable power of attorney ☐ health care directive

SOCIAL HISTORY

Do you use the following?
Tobacco ☐ yes ☐ no If yes, packs/day_____ for_____years _____Recreational drugs: ☐ yes ☐ no If yes, Type____________
Alcohol ☐ yes ☐ no If yes, drinks/day_____/ week _____Caffeine: ☐ yes ☐ no If yes, how much / day ________________
Herbal Supplements / Remedies ☐ yes ☐ no If yes, describe ____

Signature____________________________________**Relationship to patient**____________________ **Date**_____________