



ADVANCED GASTROINTESTINAL SPECIALISTS, P.C.

Leading the way in experienced, compassionate & results-driven care.

PATIENT HISTORY QUESTIONNAIRE

To Be Completed By Patient Prior To First Appointment

NAME: _____

DATE OF BIRTH: _____ TODAY'S DATE: _____

PRIMARY PHYSICIAN: _____

Describe the symptoms, and length of time of symptoms that led to your appointment.

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

Constitutional: **Yes** **No**

- Weight Gain
- Night sweats/hot flashes
- Weight Loss
- Fever
- Fatigue

HEENT: **Yes** **No**

- Frequent Headaches
- Double/blurred vision
- Hearing Loss
- Glaucoma

Respiratory: **Yes** **No**

- Difficulty breathing
- Shortness of breath
- New cough

Cardiovascular: **Yes** **No**

- Chest pain or pressure
- Heart palpitations/fluttering
- Heart Murmur

Vascular: **Yes** **No**

- Leg cramps with walking (Claudication)
- Change of color in hands or feet (Raynaud's)

Dermatologic (Skin): **Yes** **No**

- Itching
- Any rashes, sores, color changes or spots on skin

Hematology: **Yes** **No**

- Easy bruising or bleeding
- Frequent nose bleeds

Gastrointestinal: **Yes** **No**

- Frequent Nausea and/or vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Heartburn and/or Indigestion
- Difficulty swallowing
- Increased belching or burping
- Loss of appetite
- Abdominal pain
- Passing excessive gas
- Vomited any blood
- Blood in your stool
- Blood on toilet tissue
- Leaking stool or accidents
- Mucous in your stool
- Jaundice (skin or whites of eyes)
- Any acid reflux (stomach acid taste) or regurgitation
- Change in Bowel Habits

Genitourinary: **Yes** **No**

- Frequent or painful urination
- Blood in urine

Neuro/Psychiatric: **Yes** **No**

- Fainting or dizzy spells
- Emotional Problems
- Convulsions or seizures
- Numbness/tingling

Musculoskeletal: **Yes** **No**

- Joint Pain
- Back Pain

Reproductive: **Yes** **No**

- Menstrual difficulty
- Menstrual flow more than 5 days
- Menstrual Periods more frequent than every 4 weeks



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HAVE YOU EVER HAD OR DO YOU HAVE (CHECK IF YES):

- () Alcoholism () Bleeding disorder () Heart By-Pass () Lupus/RA
() Anemia () Cancer: () Heart Disease () Mental illness
() Angina/heart attack () Colitis () Heart Stent () Sleep apnea:
() Arthritis () Crohn's Disease () Hepatitis () Stroke
() Artificial Heart Valve () Diabetes () High blood pressure () Thyroid problem
() Asthma/hay fever () Emphysema () HIV/AIDS () Tuberculosis
() Atrial Fibrillation () Epilepsy or seizures () Kidney disease () Other:
() Birth defects () Glaucoma () Liver problems () Other:
() Bladder disease () Headaches () Lung problems

Comments:

HAS ANYONE IN YOUR FAMILY HAD:

- () Celiac Sprue Relationship: () Crohn's Disease Relationship: () Diabetes Relationship: () Hepatitis Relationship:
() Liver Problems Relationship: () Pancreatitis Relationship: () Ulcerative colitis Relationship: () Ulcers Relationship:
() Alcoholism () Bleeding disorder () Headaches () Lupus/RA
() Anemia () Cancer: () Heart failure () Mental Illness
() Angina/heart attack () Emphysema () High blood pressure () Stroke
() Arthritis () Epilepsy or seizures () HIV/AIDS () Thyroid problems
() Bladder Disease () Glaucoma () Kidney disease () Tuberculosis
() Lung problems () Other:

Comments:

DO YOU?

- () Exercise regularly? () Use Alcohol? () Use tobacco: () Use drugs:
Type: () Beer () Wine () Liquor () Cigarettes () Cigars () Pipe () Marijuana () Heroin
How Often: How Often: () Snuff () Chewing tobacco () Cocaine () LSD () Crack
How Many: How Often: How Often:

Occupation:

Have any children? () Y () N If yes, how many:

What questions would you like answered at your visit?

- 1.
2.
3.



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LIST ANY HOSPITALIZATIONS AND SURGERIES

REASON	YEAR	HOSPITAL	PHYSICIAN

HAVE YOU HAD ANY OF THE FOLLOWING DONE?

	YES	NO	DATE	WHERE?
Hidden blood in stool test				
Upper GI X-ray				
Lower GI X-ray (Barium Enema)				
CT Scan or MRI of Abdomen				
Sigmoidoscopy				
Colonoscopy				
Upper Endoscopy				

FAMILY HISTORY

	ALIVE	DECEASED	AGES	IMPORTANT MEDICAL PROBLEMS
FATHER				
MOTHER				
BROTHER(S) / SISTER(S)				
CHILDREN				

(Circle which) YES (Who) NO YES (Who) NO

Family history of: Colon Cancer or Polyps			Family history of other cancers?		
Family history of: Crohn's or Ulcerative Colitis			Family history of liver disease?		



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PATIENT DATA SHEET

Patient Name: (FIRST) (MIDDLE) (LAST)

Address: City: St.: Zip:

Home Phone: Cell Phone: Work Phone: Email:

Social Security #: Date of Birth: Age: Sex: M F Marital Status: S M D W

Employer: Address:

Primary Doctor's Name: Phone Number:

Who referred you to our office: Doctor's Name: Phone Number:

Do you need to have authorization to cover this visit? Yes No Authorization #

INSURANCE INFORMATION:

We file your insurance as a courtesy to you, the patient. Please note that we will file your insurance per the information provided to us. Should your insurance deny any charge, you may be held responsible for that charge.

(Copy of insurance card must be presented in order to file)

Table with 3 columns: Insurance Co. #1, Insurance Co. #2, Insurance Co. #3. Rows include Name, Address, Ins. Co. Phone #, Policy Holder Name, Policy Holder Date of Birth, Relationship to patient, Policy ID #, Group #, Effective Date.

**EMERGENCY CONTACT: (NAME): RELATION:

**EMERGENCY PHONE #: OTHER CONTACT PHONE #: (CELL PHONE,ETC.)

I authorize payment of medical benefits billed to my insurance to Advanced Gastrointestinal Specialists, P.C. I hereby accept responsibility for any service(s) provided to me that are not covered by my insurance policy. I also accept responsibility for fees that exceed the payment by my insurance, if A.G.S., P.C. does not participate with my insurance. I agree to pay all co-payments, coinsurance and deductibles at the time the service is rendered.

