inSite
DIGESTIVE HEALTH CARE

Patient Information Form

All sections of this form are required and must be completed prior to seeing the doctor.

Patient Full Name

Occupation **C if current R if retired** C R

1 Select any previous procedures you've had: ○ None

Type	Date
○ Appendix Removed	
○ Ovaries Removed	
○ Uterus Removed	
○ Gallbladder Removed	
○ Coronary Artery Bypass	
○ Coronary Stent	
○ Blood Transfusion	
○ Prostate Surgery	
○ Hip Replacement	
○ Knee Replacement	
○ Cancer Operation	
Type of Cancer:	
○ Hernia Repair	
○ Bariatric Surgery	
○ Thyroid Removed	
○ Hemorrhoid Operation	
○ Back/Neck Surgery	
○ Bladder/Kidney Surgery	
○ Heart Valve Surgery	
○ Pacemaker	
○ C-section	
○ Other:	
○ Other:	
○ Other:	

2 Select any previous tests you've had: ○ None

Type	Date
○ Colonoscopy	
○ Upper Endoscopy	
○ Abdominal Ultrasound	
○ Abdominal CT Scan/MRI	
○ GI Xrays, scans or scopes	
Specify:	
○ Other:	
○ Other:	
○ Other:	

3 Do you suffer from sleep apnea? ○ Yes ○ No

4 Have you undergone any radiation therapy?

○ Yes: _____ ○ No
(specify the reason)

5 Date of most recent blood test: / /

6 Do you use home oxygen?

○ Yes: _____ ○ No
(specify the reason)

7 Do you use a wheelchair or a walker?

○ Yes: _____ ○ No

8 Your past or present medical conditions: ○ None

Gastroenterology	Cardiovascular	Nervous System	Other (cont.)
○ Ulcer	○ Coronary Heart Disease	○ Depression	○ Anemia
○ Colon Polyps	○ High Blood Pressure	○ Psychiatric Care	○ Cancer
○ Hemorrhoids	○ High Cholesterol	○ Epilepsy/Seizure	Specify type:
○ GERD/Acid Reflux	○ Angina	○ Anxiety Disorder	○ Fibromyalgia
○ Diverticulitis	○ Heart Attack (specify date)	○ Bipolar Disorder	○ Enlarged Prostate
○ Eating Disorder	○ Other:	○ Parkinson's Disease	○ Diabetes Mellitus
○ Irritable Bowel Syndrome	○ Other:	○ Transient Ischemic Attack (TIA) or stroke	○ Gout
○ Hepatitis B	**Respiratory**	○ Severe Insomnia	○ Thyroid Disorder
○ Hepatitis C	○ Pneumonia	○ Other:	○ Alcoholism
○ Cirrhosis	○ Bronchitis	○ Other:	○ Chemical Dependency
○ Crohn's/Ulcerative Colitis	○ Asthma	**Other**	○ Bleeding Disorders
○ Chronic Constipation	○ Emphysema	○ HIV	○ Arthritis
○ Other:	○ Tuberculosis	○ Genital Herpes	○ Chronic Kidney Disease
○ Other:	○ Other:	○ Other:	○ Blood Clots
○ Other:	○ Other:	○ Other:	○ Spine Disease

9 Do you have any drug allergies? ○ No known drug allergies ○ Yes, specify: _____

10 Do you have any other allergies? ○ No known allergies ○ Yes, specify: _____

11 Have you had any recent immunizations? ○ None

○ **Flu** When: _____ ○ **Pneumonia** When: _____ ○ **Shingles/Zoster** When: _____ ○ **Hepatitis A** When: _____ ○ **Hepatitis B** When: _____ ○ **Other:** When: _____

12 **Please list or attach current list of medications, including supplements, blood thinners, herbals, and OTC meds.** ○ **None**

Name	Dose	Name	Dose

Name of pharmacy _____ Pharmacy Phone _____

Pharmacy street address _____ City _____ State _____ Zip _____

13 **Typical alcohol use.** ○ **None**

Type	Quantity
○ Beer	cans / week
○ Liquor	shots / week
○ Wine	glasses / week

14 **Typical caffeine consumption.** ○ **None**

- ○ 1-3 cups of coffee, tea, or soda daily
- ○ 4 or more cups of coffee, tea, or soda daily

15 **Typical tobacco use.**

- ○ Everyday smoker
- ○ I smoke, but not daily
- ○ Former smoker
- ○ Never smoker

16 **Please specify use of recreational drugs (past or present).** ○ **None**

Do you currently use marijuana? ○ Yes ○ No

○ Narcotics/Opiate ○ Current ○ Recent ○ Speed ○ Current ○ Recent

○ Cocaine ○ Current ○ Recent ○ Other: _____ ○ Current ○ Recent

17 **How often do you exercise?**

○ Never ○ _____ times per week

18 **Family Medical History**

○ Patient has no knowledge of family history

	Mother		Father		Any Brother		Any Sister	
Alive?	Y	N	Y	N	Y	N	Y	N
Curent Age or Age at Death								
Cause of Death								
Please specify if any relatives were diagnosed with the following:								
Ulcerative Colitis	○		○		○		○	
Colon Polyps	○		○		○		○	
Colon Cancer	○		○		○		○	
Diabetes	○		○		○		○	
Crohns Disease	○		○		○		○	
GI Cancer (stomach, liver, biliary or pancreas)	○		○		○		○	
Mental Disorder	○		○		○		○	
Celiac Disease	○		○		○		○	
Other:	○		○		○		○	
Other:	○		○		○		○	
Other:	○		○		○		○	

19 **Healthcare Information**

Do you have durable power of attorney for healthcare decisions, POLST, or similar end-of-life instruction form?

○ Yes ○ No

Can we leave test results or medical information messages for you on your home or cell phone voicemail?

○ Yes ○ No

For Office Use Only

Reviewed with:

○ Patient ○ Parent ○ Guardian

○ Daughter ○ Son ○ Spouse

Full Name:

By signing below, I certify that the health information I have provided is correct to the best of my knowledge. I consent to be treated by the staff and providers of inSite Digestive Health Care (formerly known as Southern California Gastroenterology Associates) and authorize them to release any medical information necessary to process claims. I authorize the doctor to obtain my medical records, demographic and insurance information from prior hospitals, pharmacies, laboratories or medical groups and organizations who have provided medical services if this information is needed for the doctor to provide medical services.

Patient Signature _____ Patient Full Name _____ Date _____