PATIENT INFORMATION

Date_____

Name_____
First Middle Last

Address_____

City_____State____Zip_____Home #_____Cell #_____

☐ Check this box to authorize text messaging for confirming and reminders

Email_____☐Check this box to authorize our office to email you

Employer_____Work #_____

Emergency Contact_____Phone #_____

Marital Status_____SSN_____Birthdate_____Sex M/F (please circle)

Preferred Language:☐English ☐Spanish ☐Russian ☐Other _____ Ethnicity: ☐Hispanic/Latino ☐Non-Hisp.

Race: ☐White ☐Native American ☐African American ☐Asian ☐Other _____

Referred by_____Family Physician_____

Are we currently seeing one of your family members at our practice, or have we previously? YES NO If so, patient's name:_____

GUARANTOR INFORMATION

Name_____
First Middle Last

Address_____ City _____State_____Zip_____Home #_____

Employer_____Work # _____ SSN _____Birthdate_____Sex_____

INSURANCE INFORMATION

Primary Insurance_____

Subscriber_____Subscriber ID_____

Group #_____Co-Pay Amount_____

Secondary Insurance_____

Subscriber_____Subscriber ID_____

Group #_____Co-Pay Amount_____

I herby authorize my insurance benefits to be paid directly to the doctor. I authorize the doctor or the insurance company to release any information required for this claim. I am financially responsible for any balance due and any collection costs should action need to brought to collect payment.

Signature_____Date_____

Please turn page over and continue

Patient Name: _____ Date: _____

MEDICATION LIST

Please list all of your current medications that you take regularly or occasionally, nonprescription medications, vitamins, and supplements. Please include dosage and frequency of taking for each medication. Include medicines discontinued or changed in past 8 weeks.

START DATE	NAME OF MEDICATION	DOSAGE AND DIRECTIONS	REASON FOR TAKING	DATE STOPPED

Please list drug and food allergies

_____

_____

Patient Name: _____ Date: _____

Valley Gastroenterology

12401 E Sinto Ave.
Spokane Valley, WA 99216
P: 509-922-2055 / F: 509-922-2307

Paul M. Craig, MD **Clinton S. Poppel, MD**
Amelia Williams, PA-C **Lindsay Adams, ARNP**

Patient Health History Questionnaire

Name: _____
First MI Last

Date of Birth: ___/___/_____ Age: _____ Primary Care Physician: _____

Brief Reason for Visit today: _____

Past Medical History (Have you had any of the following medical problems or surgeries?):

High blood pressure	Y	N	_____	Barrett's esophagus	Y	N	_____
Irregular heart rhythm	Y	N	_____	Stomach ulcers	Y	N	_____
Angina	Y	N	_____	Pancreatitis	Y	N	_____
Heart attack	Y	N	_____	Gallstones	Y	N	_____
Congestive heart failure	Y	N	_____	Liver disease	Y	N	_____
Heart Angioplasty	Y	N	_____	Hepatitis	Y	N	_____
Heart Stent	Y	N	_____	Cirrhosis	Y	N	_____
Heart bypass	Y	N	_____	Irritable Bowel Syndrome	Y	N	_____
Heart valve replacement	Y	N	_____	Wheat intolerance	Y	N	_____
Aortic aneurysm repair	Y	N	_____	Milk intolerance	Y	N	_____
				Crohn's disease	Y	N	_____
Asthma	Y	N	_____	Diverticulosis	Y	N	_____
Emphysema	Y	N	_____	Diverticulitis	Y	N	_____
Pneumonia	Y	N	_____	Ulcerative colitis	Y	N	_____
Obstructive Sleep Apnea	Y	N	_____	Colon polyps removal	Y	N	_____
Using CPAP	Y	N	_____	Colon polyps PRIOR to age 50	Y	N	
Stroke	Y	N	_____	Colon cancer removal	Y	N	_____
Seizures	Y	N	_____	Colon cancer removal PRIOR to age 50	Y	N	
Migraines	Y	N	_____	Breast cancer removal	Y	N	_____
Anxiety	Y	N	_____	Ovarian cancer removal	Y	N	_____
Depression	Y	N	_____	Uterine cancer removal	Y	N	_____
Alcoholism	Y	N	_____	Skin Cancer removal	Y	N	_____
				Appendix removal	Y	N	_____
Diabetes	Y	N	_____	Anti-Reflux surgery	Y	N	_____
Thyroid disease	Y	N	_____	Stomach surgery	Y	N	_____
				Pancreas surgery	Y	N	_____
Kidney stones	Y	N	_____	Gallbladder removal	Y	N	_____
Poor kidney function	Y	N	_____	Bowel obstruction repair	Y	N	_____
				Colon surgery	Y	N	_____
Reflux disease	Y	N	_____	Hemorrhoid surgery	Y	N	_____
Esophageal stricture	Y	N	_____	Hernia repair	Y	N	_____

Please turn page over and continue

Patient Name: _____ Date: _____

Breast surgery	Y	N	_____	Organ transplant	Y	N	_____
Breast biopsy	Y	N	_____	Prostate Surgery	Y	N	_____
Tubal ligation	Y	N	_____	Caesarean Section	Y	N	_____
Complete Hysterectomy	Y	N	_____	Bladder Suspension	Y	N	_____
Partial Hysterectomy	Y	N	_____	Spleen Removal	Y	N	_____
Joint replacement	Y	N	_____	Gastric Bypass/Banding	Y	N	_____

Social History (Please answer the following questions; use your best estimates):

WHAT IS YOUR MARITAL STATUS? Single Partnered Married Separated Divorced Widow
ARE YOU WORKING? Y N Occupation? _____

(**For the following, please describe best estimate on weekly use over the past 6 months**)

DO YOU DRINK COFFEE? Y N How much and often? _____
DO YOU DRINK SODA? Y N How much and often? _____
DO YOU EAT DAIRY PRODUCTS? Y N How much and often? _____
DO YOU USE TOBACCO PRODUCTS? Y N
DO YOU USE MARIJUANA OR CANNABIS PRODUCTS? Y N
DO YOU DRINK ALCOHOL? Y N How much and often? _____
HAVE YOU LEFT THE US IN PAST 6 MOS? Y N Where to and when? _____
HAVE YOU HAD A BLOOD TRANSFUSION? Y N When? _____
DO YOU HAVE A HISTORY OF RECREATIONAL DRUG USE? Y N Explain? _____

Family Medical History

Is there a history of the following in your family <u>EXCLUDING YOURSELF</u>? (Please circle Y or N, and indicate who):

STOMACH CANCER	Y_____	N	GALLBLADDER DISEASE	Y_____	N
SMALL INTESTINE CANCER	Y_____	N	LIVER DISEASE	Y_____	N
PANCREATIC CANCER	Y_____	N	COLON POLYPS	Y_____	N
KIDNEY OR URETER CANCER	Y_____	N	COLON CANCER	Y_____	N
BLADDER CANCER	Y_____	N	BREAST CANCER	Y_____	N
ULCER DISEASE	Y_____	N	UTERINE CANCER	Y_____	N
ULCERATIVE COLITIS	Y_____	N	OVARIAN CANCER	Y_____	N
CROHN'S DISEASE	Y_____	N			
DIVERTICULOSIS	Y_____	N			

Do you have any first-degree relatives <u>PRIOR</u> to age 50 with the following? (Please circle)

Colorectal Cancer Uterine Cancer Ovarian Cancer Stomach Cancer Small Intestine Cancer
Urinary Tract Cancer Bile Duct Cancer Pancreatic Cancer Brain Cancer

Do you have 3 or more relatives with Colorectal cancer? Y N

Please turn page over and continue

Patient Name: _____ Date: _____

GI System Review: (Please indicate if you had any of the symptoms listed below left in the past 6 months. Use space to right to indicate when this occurred):

Weight Loss > 10lb	Y	N	_____	Diarrhea	Y	N	_____
Fever	Y	N	_____	Constipation	Y	N	_____
Loss of appetite	Y	N	_____	Stool incontinence	Y	N	_____
Nausea	Y	N	_____	Mucous in stool	Y	N	_____
Vomiting	Y	N	_____	Blood in stool	Y	N	_____
Heartburn	Y	N	_____	Black stool	Y	N	_____
Chest Pain	Y	N	_____	Light-colored stool	Y	N	_____
Trouble swallowing	Y	N	_____	Fat droplets in stool	Y	N	_____
Painful swallowing	Y	N	_____	Abdominal swelling	Y	N	_____
Abdominal pain	Y	N	_____	Rectal pain	Y	N	_____
Increased gas	Y	N	_____	Anal pain	Y	N	_____
Change in bowels	Y	N	_____				

Non – GI System Review (On the lists below, circle problems you have):

FATIGUE	GENERAL WEAKNESS	CHILLS	NIGHT SWEATS	DIFFICULTY SLEEPING
EYE PAIN	DRY EYES	YELLOW EYES	VISION CHANGE	FREQUENT NOSE BLEEDS
HEARING LOSS	SORE THROAT	HOARSENESS	SINUS PROBLEMS	NON-HEALING MOUTH SORES
WHEEZING	COUGH WITH COLORED SPUTUM	COUGH WITH BLOOD	DRY COUGH	SHORTNESS OF BREATH
HEART MURMUR	HEART RACING	COLD HANDS/FEET	CALF OR LEG PAIN	SHORTNESS OF BREATH ON EXERTION
GOUT	COLD INTOLERANCE	INCREASED THIRST	INCREASE URINE	HEAT INTOLERANCE
NOW PREGNANT	BREAST CHANGES	CHANGED MENSES	HOT FLASHES	DECREASED LIBIDO
BLOODY URINE	PAINFUL URINE	WEAK URINE	URINE AT NIGHT	INCREASED FREQUENCY OF URINATION
GENITAL PAIN	GENITAL LUMP	GENITAL SORE	GENITAL DISCHARGE	INTERCOURSE PAIN
CHANGED GLANDS	BLOOD CLOTS	EASY BRUISING	ABNL BLEEDING	HIV POSITIVE
DIZZINESS	HEADACHES	NUMBNESS	UNUSUAL FORGETFULNESS	MENTAL ILLNESS
JOINT PAIN	JOINT SWELLING	TREMORS	UNSTABLE WALKING	MUSCLE WEAKNESS
CHRONIC RHINITIS	FREQUENT COLDS	HAY FEVER	ITCHY EYES	HIVES
RASHES	SKIN COLOR CHANGE	ITCHING	DRY SKIN	ABNORMAL MOLES