Indianapolis Gastroenterology and Hepatology
& The Endoscopy Center at St. Francis
317-865-2955 / 800-403-4683
www.IndyGastro.com

PLACE PATIENT LABEL HERE

****PLEASE USE BLACK PEN ONLY****

Patient Last Name:	First:	Middle:	Date:	Sex: F M

PATIENT INFORMATION

Date of Birth:	Marital Status (circle one): Single Married Separated Divorced Widowed	Social Security Number:
Race (circle one): African American, American Indian, Asian, Hawaiian, White, Other:____________	Language (circle one): English Spanish Other:__________	
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell:
Email:		
Employer:	Occupation:	
Spouse's Name:	Spouse's Date of Birth:	
Primary Care Physician:	Referring Physician:	
Preferred Pharmacy (Name & Address):	Phone:	

Insurance Information

You must present your insurance card at every visit

Insurance Plan:	Insurance Policy Holder Name and DOB (person responsible for bill):
Relationship to Policy Holder:	Policy Holder Phone:
Insurance ID Number:	Insurance Group Number:
Insurance Billing Address *(back of card):*	Pre-Certification Phone (*back of card*):

In Case of Emergency

Name of friend or relative (not living at your address):	Relationship:	Phone:

Do you have an Advanced Medical Directive (Living Will)? ☐ YES ☐ NO (information provided upon request)

The Endoscopy Center at St. Francis, LLC will always attempt to resuscitate a patient and transfer the patient to a hospital in the event of deterioration. INITIAL________________ Copy provided ☐ YES ☐ NO

Social History

Do you take recreational or street drugs? ☐ YES ☐ NO If YES, list:

DO YOU USE:	YES	NO	AMOUNT	DO YOU USE:	YES	NO	AMOUNT
Caffeinated Beverages (Coffee, Tea, Soda)				Cigarettes			
Beer				Other Tobacco			
Other Alcohol							

What Symptoms/problems brought you in to see the doctor today?

____

Are you now in poor health or suffering from any chronic physical or mental condition ☐ YES ☐ NO If YES, what? ________________________________

Allergies: ☐ No Known Drug Allergies ☐ YES (If Yes, Please List allergies Below) Medication/Chemicals/Vaccine/Environmental		Are you currently taking prescription or over-the-counter medications or herbal supplements? ☐ YES ☐ NO If yes, list below:			
NAME	REACTION	MEDICATION NAME	DOSAGE	HOW OFTEN	REASON

Medical History

(Check any past or current problems)

☐ Skin	☐ Lungs	☐ Chronic or recurrent diarrhea	☐ Loose/chipped/capped teeth
☐ Headache	☐ Asthma	☐ Kidney/urinary bladder	☐ Ulcer - stomach or duodenum
☐ Eyes	☐ Bronchitis	☐ Uterus/ovaries/testicles	☐ Nausea / vomiting (at present)
☐ Ears	☐ Chronic cough	☐ Bleeding	☐ Frequent / severe abdominal pain
☐ Nose	☐ Breathing Problems	☐ High blood pressure	☐ Weight loss / gain
☐ Mouth	☐ Emphysema	☐ Stroke	☐ Yellow jaundice
☐ Throat	☐ Sleep apnea	☐ Diabetes	☐ Hepatitis
☐ Hoarseness	☐ Arthritis/joint problems	☐ Circulation	☐ Gallbladder
☐ Heartburn	☐ Tuberculosis	☐ Seizures	☐ Small intestine / colon
☐ Swallowing	☐ Rheumatic fever	☐ Pacemaker/internal defibrillator	☐ Frequent / severe constipation
☐ Stomach	☐ Joint replacement	☐ Artificial heart valve	☐ Blood in stools or "tar-like" stools
☐ Chest Pain	☐ Neck injury	☐ Blood thinner use	☐ Depression or mental illness

☐ Daily aspirin/ibuprofen ☐ Cancer Location: ____

☐ Problems with conscious sedation / anesthesia? Describe:____

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):_____________________________________

Check all that applies:

Father: ☐ Ulcerative colitis ☐ Crohn's Disease ☐ Lung Disease ☐ Kidney Disease ☐ Heart Disease ☐ Colon Polyps ☐ Colon Cancer

Mother: ☐ Ulcerative colitis ☐ Crohn's Disease ☐ Lung Disease ☐ Kidney Disease ☐ Heart Disease ☐ Colon Polyps ☐ Colon Cancer

Siblings: ☐ Ulcerative colitis ☐ Crohn's Disease ☐ Lung Disease ☐ Kidney Disease ☐ Heart Disease ☐ Colon Polyps ☐ Colon Cancer

Grandparent: ☐ Ulcerative colitis ☐ Crohn's Disease ☐ Lung Disease ☐ Kidney Disease ☐ Heart Disease ☐ Colon Polyps ☐ Colon Cancer

List any previous illnesses / hospitalizations / surgeries / procedures: (Additional paper available upon request)

DATE	**HOSPITAL**	**SURGERY / TREATMENT**

The above information is accurate to the best of my ability: ____________________________________ ____________________

PATIENT SIGNATURE **DATE**

Patient Verifies that no changes have been made in 30 days of last visit: ___________ INITIALS ___________ DATE