NORTHSIDE GASTROENTEROLOGY, INC. – PATIENT INFORMATION – PLEASE PRINT

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE NUMBER : (_____)_____ CELL PHONE NUMBER: (____)_____

MARITAL STATUS: M D S W SOCIAL SECURITY NUMBER: _____ GENDER: (M/F)
RACE:_____ PREFERRED LANGUAGE: _____
ETHNICITY: _____ Hispanic Latino _____ Not Hispanic Latino

EMPLOYER: _____ WORK PHONE: (_____)_____EXT. _____
EMERGENCY CONTACT/RELATIONSHIP: _____ PH #: (_____)_____

REFERRING PHYSICIAN: _____ PRIMARY CARE DOCTOR: _____

REASON FOR VISIT: _____

PAST/PRESENT MEDICAL CONDITIONS:_____

REVIEW OF SYSTEMS: Please CIRCLE yes/no if you have any of the following symptoms.

General: **Fevers** **Weight Loss/Gain___lbs.** **Night Sweats** **Fatigue**

Gastrointestinal: **Persistant Nausea** **Frequent Vomiting** **Heartburn/Reflux** **Difficulty Swallowing**
Abdominal Pain **Bloating** **Blood in Stools** **Excessive Gas**
Constipation **Diarrhea** **Jaundice/Yellow Skin** **Hemorrhoids**

Head, Ears, Eyes, Nose, Throat: **Headache** **Vision Loss** **Neck Pain** **Swollen Glands**

Respiratory: **Cough** **Difficulty Breathing** **Bloody Sputum**

Cardiac: **Chest Pain** **Shortness of Breath** **Heart Skips Beats/Beats Too Fast**

Neurological: **Dizziness** **Seizures** **Stroke**

Psychiatric: **Anxiety** **Depression**

Skin: **Itching** **Bruising** **Rash**

Musculoskeletal: **Muscle Pain** **Muscle Swelling**

Hematology: **Blood Clots** **Excessive Bleeding**

SOCIAL HISTORY:

Do you smoke?	Y	N	If yes, _____ packs a day for _____ years.
Previous Smoker?	Y	N	If yes, _____ packs a day for _____ years.
Do you drink alcohol?	Y	N	If yes, how many drinks a week _____.
Previous drinker?	Y	N	If yes, for how long? _____

FAMILY HISTORY (LIST MEDICAL CONDITIONS):

Father: _____ Mother: _____
Sister: _____ Brother: _____
Grandparents: _____

SURGERIES (Even as a child): _____

_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Include all prescriptions, vitamins and over-the-counter drugs taken on a regular basis.

Name of Medication	Dosage	Frequency

Allergies to Medications, Foods, or Seasonal (If no allergies, write NONE)	Reaction

Pharmacy Name: _____

Pharmacy Phone: (_____)_____ **Pharmacy Address:**_____

Mail Order Pharmacy Name: _____ **Phone Number:** _____ **Fax Number**: _____

I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay Northside Gastroenterology, Inc. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in effect until such time it is revoked by me.

_____ _____

Signature of Patient/Guardian Date