GRAND TETON GASTROENTEROLOGY
an affiliate of Mountain View Hospital

PATIENT GASTROENTEROLOGY HISTORY FORM

PATIENT DEMOGRAPHICS

DEMOGRAPHICS

Patient's Name: ______________________ **Date:** __________

DOB: ___/___/___ **Birth Gender:** ◯ M ◯ F **Pref. Gender:** ◯ M ◯ F **Ht:** ______ **Wt:** ______

Address: ______________________ **City:** __________ **State:** ______ **Zip:** ______

Email: ______________________

Main Phone #: __________ **Alternate #:** __________ **Work #:** __________

Marital Status: ◯ Single ◯ Married ◯ Other: __________

Emergency Contact: __________ **Relationship:** __________ **Phone #:** __________

Primary Provider: __________ **Referring Provider:** __________

Pharmacy: __________ **Home Health/Care Facility:** __________

Do you have an Advance Directive? ◯ Yes ◯ No

Type: ◯ Living will ◯ Medical durable power of attorney ◯ Other: __________

OTHER INFORMATION

Which racial category do you most closely identify with?

◯ Caucasian ◯ African American ◯ American Indian/Alaska Native ◯ Asian ◯ Other: __________

Ethnicity: ◯ Not Hispanic or Latino ◯ Hispanic or Latino

What is your language preference? ◯ English ◯ Spanish ◯ Other: __________

INSURANCE

Primary Insurance: __________ Policy/ID #: __________ Group #: __________

Name of Policy Holder: __________ DOB: ___/___/___ Employer: __________

Secondary Insurance: __________ Policy/ID #: __________ Group #: __________

Name of Policy Holder: __________ DOB: ___/___/___ Employer: __________

RESPONSIBLE PARTY

Parent/Responsible Party Name: __________ DOB: ___/___/___

Relationship: __________ City: __________ State: ______ Zip: ______

Main Contact#: __________ Alternate #: __________ Work #: __________

PATIENT PORTAL

I acknowledge that Grand Teton Gastroenterology uses patient portal for the majority of communication, including lab, pathology, radiology results, etc. I understand that unless I opt out of the patient portal, I agree to receive majority of communication and results through the patient portal.

Email Address: ______________________

◯ I chose to opt out of patient portal and understand I will be subject to longer communication wait times and test results. I may be required to schedule an appointment to go over any questions I may have regarding my health and/or treatment plans. Any record requests will be subject to $1 per page and may take up to 2 weeks for preparation.

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RESEARCH AUTHORIZATION

I hereby authorize Grand Teton Gastroenterology to disclose protected health information to Grand Teton Research Group, PLLC for the purpose of my potential participation in research studies. I understand that this is to only review my personal health information to determine if there is a current or future research study that would fit criteria for my personal diagnosis. I understand if I become a candidate for a research study, I will be contacted by Grand Teton Research Group for further consent.

I understand that a revocation is not effective to the extent that the Facility has relied on the use of disclosure of protected health information.

I understand that the information used to disclose pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that the Facility will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

◯ I consent to Grand Teton Research, PLLC reviewing my diagnosis and protected health information to determine if I am a candidate for current and/or new research studies.

◯ I do not consent for my protected health information to be released.

RELEASE OF INFORMATION

I, ______________, hereby authorize Grand Teton Gastroenterology to disclose my protected health information to persons/organization listed below:

Name: ______________________ Relationship: ____________ PH: ____________

Name: ______________________ Relationship: ____________ PH: ____________

Name: ______________________ Relationship: ____________ PH: ____________

This release will remain in effect until we receive written notification from you.

Signature of Patient or Guardian: ______________________ Date: ____________

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PATIENT GASTROENTEROLOGY HISTORY FORM

MEDICAL HISTORY FORM - Continued

MEDICATION AND ALLERGIES

Blood Thinners: ◯ None
◯ Aleve ◯ Aspirin ◯ Celebrex ◯ Coumadin ◯ Eliquis ◯ Heparin ◯ Ibuprofen
◯ Lovenox ◯ Mobic ◯ Motrin ◯ Pradaxa ◯ Plavix ◯ Warfarin ◯ Xarelto

Medication: ____________ Dose: ________ Frequency: ________
Medication: ____________ Dose: ________ Frequency: ________
Medication: ____________ Dose: ________ Frequency: ________
Medication: ____________ Dose: ________ Frequency: ________
Medication: ____________ Dose: ________ Frequency: ________
Medication: ____________ Dose: ________ Frequency: ________
Medication: ____________ Dose: ________ Frequency: ________

Medication Allergies: ◯ Negative

Allergy: ____________ Reaction: ____________
Allergy: ____________ Reaction: ____________
Allergy: ____________ Reaction: ____________
Allergy: ____________ Reaction: ____________
Allergy: ____________ Reaction: ____________

Are you allergic to Latex? ◯ Yes ◯ No
Are you allergic to Iodine? ◯ Yes ◯ No

MEDICAL HISTORY

Symptoms/Disease	Self	Father	Mother	Brother	Sister	No History
Alcoholism	◯	◯	◯	◯	◯	◯
Bleeding Tendency	◯	◯	◯	◯	◯	◯
Cancer	◯	◯	◯	◯	◯	◯
Colon Polyps	◯	◯	◯	◯	◯	◯
Colon Cancer	◯	◯	◯	◯	◯	◯
Colitis	◯	◯	◯	◯	◯	◯
Crohn’s Disease	◯	◯	◯	◯	◯	◯
Liver Disease	◯	◯	◯	◯	◯	◯
Stomach Cancer	◯	◯	◯	◯	◯	◯
Ulcer Disease	◯	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯	◯
	◯	◯	◯	◯	◯	◯
STD’s	◯					
HIV/AIDS or Hepatitis	◯					

Father’s Age: ______ ◯ Living ◯ Deceased Cause of Death (if applicable) ____________
Mother’s Age: ______ ◯ Living ◯ Deceased Cause of Death (if applicable) ____________

MEDICAL HISTORY FORM - Continued

SURGICAL HISTORY

Past and Present Surgical History:

Surgery: ______________________ Date: __________ Physician: ______________

Surgery: ______________________ Date: __________ Physician: ______________

Surgery: ______________________ Date: __________ Physician: ______________

Surgery: ______________________ Date: __________ Physician: ______________

Surgery: ______________________ Date: __________ Physician: ______________

Surgery: ______________________ Date: __________ Physician: ______________

Surgery: ______________________ Date: __________ Physician: ______________

SOCIAL HISTORY

Tobacco History:

Do you use tobacco product? ◯ Yes ◯ No What type: ____________________

Are you a former smoker? ◯ Yes ◯ No

If yes, I smoked an average of ___________ packs/day for_________ years. I quit in __________(year)

Alcohol or Drug History:

Do you consume alcohol? ◯ Yes ◯ No How often: ______ Drinks per ◯ Day ◯ Week ◯ Month

Recreational drug use: ◯ Yes ◯ No What type: ___________________

Caffeine:

Do you drink Caffeine? ◯ Yes ◯ No How often: ______ Drinks per ◯ Day ◯ Week ◯ Month

Please complete the back of this sheet.

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MEDICAL HISTORY FORM

REVIEW OF SYSTEMS

Reason for Visit: ____

____

Review of Systems

Please mark yes to any symptoms you are currently experiencing or have recently experienced

Constitutional	◯ Negative	Yes
Fever		◯
Chills		◯
Unintentional Weight Loss		◯
H.E.N.T	◯ **Negative**	**Yes**
Hearing Loss		◯
Sore Throat		◯
Respiratory/Lungs	◯ **Negative**	**Yes**
Shortness of Breath		◯
Cough		◯
Cardiovascular	◯ **Negative**	**Yes**
Chest Pain		◯
Palpitations		◯
Peripheral Edema		◯
GI (Gastrointestinal)	◯ **Negative**	**Yes**
Black/Bloody Stools		◯
Abdominal Pain		◯
Nausea/Vomiting		◯
Heartburn/Acid		◯
Constipation		◯
Loss of Appetite		◯
Use of Laxatives		◯
Cramping		◯
Diarrhea		◯

GU (Genitourinary)	◯ Negative	Yes
Pain with Urination		◯
Blood in Urine		◯
Allergy/Immunologic	◯ **Negative**	**Yes**
Food Allergy		◯
Seasonal Allergy		◯
Eyes	◯ **Negative**	**Yes**
Pain		◯
Double Vision		◯
Musculoskeletal	◯ **Negative**	**Yes**
New Back Pain		◯
Joint Pain		◯
Muscle Pain		◯
Neurologic	◯ **Negative**	**Yes**
Headache		◯
Numbness		◯
Dizziness		◯
Confusion		◯
Skin	◯ **Negative**	**Yes**
Rash		◯
Spots		◯
Bruising		◯
Jaundice		◯
Endocrine	◯ **Negative**	**Yes**
Heat or Cold Intolerance		◯
Increased Thirst of Hunger		◯