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 choose 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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COMMUNICATION CONSENT

*Phone calls through Grand Teton Gastroenterology may be recorded for quality assurance purposes

Can we leave detailed and confidential messages on your voicemail?

◯ Yes Phone Number:_____

◯ No

Can we mail test results to your home?

◯ Yes

◯ No

APPOINTMENT POLICY: NO SHOW, CANCELATIONS & LATE ARRIVALS

• We kindly request 24 business hours' notice for any cancelation. Appointments missed or canceled without sufficient notice will be subject to an $83.19 fee and/or completion of our NO-SHOW program.

• In the event that you incur two (2) documented “no-shows” and/or “same-day cancelations” you may be subject to dismissal from Grand Teton Gastroenterology due to non-compliance.

• **Please notify us if you will be late for your appointment**. Arriving 15 minutes past your scheduled time may result in rescheduling your appointment, at the discretion of the provider.

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: _____

PATIENT DEMOGRAPHICS

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. This protected health information may include: demographic information, diagnosis, medical histories, clinic notes, and test/laboratory results. I understand that the purpose for this disclosure is to determine if a current or future research study may be applicable and beneficial to 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 I can revoke, in writing, this authorization at any time. I may send this request in writing to heather@gtrgi.org or to the following physical address:
Grand Teton Research Group
2770 Cortez Ave
Idaho Falls, ID 83404

I understand that my consent to disclose my personal health information will not condition my treatment as this authorization form is NOT a consent for treatment.

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.

Printed Name:_____ Date of Birth:_____

Signature of Patient or Guardian:_____ Date:_____

GRAND TETON GASTROENTEROLOGY

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.

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		○
Trouble Swallowing		○

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		○