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| **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: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **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: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **INSURANCE** | **Primary Insurance:** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | Policy/ID #: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | Group #: | | | | | | | | | | | |  | | | | | | | |  | |
| Name of Policy Holder: | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | DOB: \_\_\_/\_\_\_/\_\_\_ | | | | | | | | | | | | | | | | | | | | Employer: | | | | | | | | | | | | | | |  | | | | | | |  | |
| **Secondary Insurance:** | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | Policy/ID #: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | Group #: | | | | | | | | | | | | |  | | | | | | |  |
| Name of Policy Holder: | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | DOB: \_\_\_/\_\_\_/\_\_\_ | | | | | | | | | | | | | | | | | | | | Employer: | | | | | | | | | | | | | | |  | | | | | | |  |
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| **RESPONSIBLE PARTY** | | Parent/Responsible Party Name: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | DOB: \_\_\_/\_\_\_/\_\_\_ | | | | | | | | | | | | | | |  |  | | |
| Relationship: | | | | | | | |  | | | | | | | | | | | | | | | | | | | City: | | | | | |  | | | | | | | | | | | | | | | | | State: | | | | | | |  | | | | | | | | | | | | | | Zip: | | | | | |  | | | | | | | | | |  |
| Main Contact#: | | | | | | | | | | |  | | | | | | | | | | | | | Alternate #: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | Work #: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  |
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| **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: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | 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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| **PATIENT DEMOGRAPHICS** | | | | | | | | |  | | | | | | |
| **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  No | | Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Can we mail test results to your home? | | | | | | | | | | |  | | |
|  | Yes  No | | |  | | | | | | |
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| **NO SHOW/ CANCELLATION POLICY** | Grand Teton utilizes a wait list daily to schedule earlier appointments for patients awaiting treatment. In order to accommodate our ill patients, we must be provided with adequate cancellation/reschedule notice.  Due to the extreme length of our wait list, 24 hours’ notice is required for office visit cancellations or reschedules. Appointment modifications without proper notice and NO SHOWs are subject to a $83.19 fee and/or fulfillment of our NO SHOW program. We thank you for your compliance. | | | | | | | | | | | | | | |
| **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 DEMOGRAPHICS** | | | | | | | | |  | | |
| **RESEARCH AUTHORIZATION** |  | | | | | | | | | |  |
| I hereby authorize Grand Teton Gastroenterology, an affiliate of Mountain View Hospital, 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, PLLC for further consent.  I understand I can revoke, in writing, this authorization at any time.    I understand that my consent on this form 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. | | | | | | |  |
|  |  | | |  |  |  |  | |  | |
| Signature | | | | | |  | Date | |  | |
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| **MEDICAL HISTORY FORM - Continued** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MEDICATION AND ALLERGIES** | **Blood Thinners:** | | | | | | | |  | None | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | |
|  |  |  | | | | | |  | Aleve | | | | | | | | |  | | Aspirin | | | | | | | |  | | | | Celebrex | | | | | | | |  | | | | Coumadin | | | | | | | | | |  | | Eliquis | | | | | | |  | | | Heparin | | | | | |  | Ibuprofen | | |
|  |  |  | | | | | |  | Lovenox | | | | | | | | |  | | Mobic | | | | | | | |  | | | | Motrin | | | | | | | |  | | | | Pradaxa | | | | | | | | | |  | | Plavix | | | | | | |  | | | Warfarin | | | | | |  | Xarelto | | |
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| Medication: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Dose: | | | | | | | | |  | | | | | | | | | | | Frequency: | | | | | | | | | | |  | | | | | |  |
| Medication: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Dose: | | | | | | | | |  | | | | | | | | | | | Frequency: | | | | | | | | | | |  | | | | | |  |
| Medication: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Dose: | | | | | | | | |  | | | | | | | | | | | Frequency: | | | | | | | | | | |  | | | | | |  |
| Medication: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Dose: | | | | | | | | |  | | | | | | | | | | | Frequency: | | | | | | | | | | |  | | | | | |  |
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| Medication: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Dose: | | | | | | | | |  | | | | | | | | | | | Frequency: | | | | | | | | | | |  | | | | | |  |
| Medication: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Dose: | | | | | | | | |  | | | | | | | | | | | Frequency: | | | | | | | | | | |  | | | | | |  |
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| **Medication Allergies:** | | | | | | | | | | | |  | | Negative | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergy: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Reaction: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Allergy: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Reaction: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Allergy: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Reaction: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Allergy: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Reaction: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Allergy: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Reaction: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **Are you allergic to Latex?** | | | | | | | | | | | | | | | Yes No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Are you allergic to Iodine?** | | | | | | | | | | | | | | | Yes No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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 | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | |  | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | |  | | | | |
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| STD’s | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | |  | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | | |
| HIV/AIDS or Hepatitis | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | |  | | | | | | | |
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| **Father’s Age:** | | | | |  | | | | | | Living | | | | | | | | | | | Deceased | | | | | | | | | | | | Cause of Death (if applicable) | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  |
| **Mother’s Age:** | | | | | | |  | | | | Living | | | | | | | | | | | Deceased | | | | | | | | | | | | Cause of Death (if applicable) | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |  |
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| **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: | | | | | | | | | |  | | | | | | | | | | | |  |
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| **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 | | | | | | | | | | | | | | | |
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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** |  | **GU (Genitourinary)** | **Negative** | **Yes** |  |
| Fever | | |  |  |  | Pain with Urination |  |  |
| Chills | | |  |  |  | Blood in Urine |  |  |
| Unintentional Weight Loss | | |  |  |  | **Allergy/Immunologic** | **Negative** | **Yes** |
| **H.E.N.T** | | | **Negative** | **Yes** |  | Food Allergy |  |  |
| Hearing Loss | | |  |  |  | Seasonal Allergy |  |  |
| Sore Throat | | |  |  |  | **Eyes** | **Negative** | **Yes** |
| **Respiratory/Lungs** | | | **Negative** | **Yes** |  | Pain |  |  |
| Shortness of Breath | | |  |  |  | Double Vision |  |  |
| Cough | | |  |  |  | **Musculoskeletal** | **Negative** | **Yes** |
| **Cardiovascular** | | | **Negative** | **Yes** |  | New Back Pain | |  |
| Chest Pain | | |  |  |  | Joint Pain | |  |
| Palpitations | | |  |  |  | Muscle Pain |  |  |
| Peripheral Edema | | |  |  |  | **Neurologic** | **Negative** | **Yes** |
| **GI (Gastrointestinal)** | | | **Negative** | **Yes** |  | Headache |  |  |
| Black/Bloody Stools | | |  |  |  | Numbness | |  |
| Abdominal Pain | | |  |  |  | Dizziness |  |  |
| Nausea/Vomiting | | |  |  |  | Confusion |  |  |
| Heartburn/Acid | | |  |  |  | **Skin** | **Negative** | **Yes** |
| Constipation | | |  |  |  | Rash |  |  |
| Loss of Appetite | | |  |  |  | Spots |  |  |
| Use of Laxatives | | |  |  |  | Bruising |  |  |
| Cramping | | |  |  |  | Jaundice |  |  |
| Diarrhea | | |  |  |  | **Endocrine** | **Negative** | **Yes** |
| Trouble Swallowing | | |  |  |  | Heat or Cold Intolerance |  |  |
|  | | |  |  |  | Increased Thirst of Hunger |  |  |
|  | | |  |  |  |  |  |  |
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