PATIENT MEDICAL HISTORY INTAKE FORM

Patient information

FOR OFFICE USE ONLY

PROVIDER: NB JG MG KK TM GAM JM KP BP DR CR AS AW HB MC VC EH HIE KR KS

LOCATION: BMC MMC PEC INT OFFICE

DATE: _____

****** PLEASE COMPLETE AND MAIL BACK ASAP ******

Reason for visit _____

Patient Full Name _____

Date of Birth_____ Age _____

Referring provider _____ Primary care provider_____

Race _____ ⬭ Decline to specify

Ethnicity _____ ⬭ Decline to specify

Sex ⬭ Male ⬭ Female ⬭ Other **Preferred Pronoun** ⬭ He ⬭ She ⬭ They/Them

Primary/Preferred Language ⬭ English ⬭ Other: _____

Preferred Pharmacy _____

Current Medications ⬭ No current medications

Name Dose

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Allergies ⬭ Patient has no known allergies ⬭ Patient has no known drug allergies

Allergy Reaction

1._____
2._____
3._____
4._____
5._____

PLEASE COMPLETE ALL PAGES - FRONT AND BACK

Social History

Occupation _____ Employer_____

Marital Status ⬭ Single ⬭ Married ⬭ Divorced ⬭ Widowed ⬭ Civil Union/Long Term Partner

Spouse name, if applicable_____

Tobacco Use ⬭ Current ⬭ Former ⬭ Never Type/years of use_____

Alcohol ⬭ Current ⬭ Former ⬭ Never Number drinks/week _____

Drug Use ⬭ None ⬭ Marijuana, frequency_____ ⬭ Other_____

Past or Present Medical Conditions

⬭ **None**

Blood ⬭ Anemia ⬭ Bleeding Disorders, specify_____

Cardiac ⬭ Atrial Fibrillation ⬭ High Blood Pressure ⬭ Heart Attack ⬭ Blood Clot (DVT/PE)
⬭ Aortic Stenosis ⬭ Pulmonary Hypertension ⬭ Congestive Heart Failure
⬭ Other Valvular Disease, type_____

Endocrine ⬭ Diabetes ⬭ Thyroid Disease

Gastrointestinal ⬭ Barrett's Esophagus ⬭ Crohn's Disease ⬭ H. Pylori ⬭ Pancreatic Cancer
⬭ Celiac Disease ⬭ Diverticulosis/itis ⬭ Irritable Bowel (IBS) ⬭ Pancreatitis
⬭ Cirrhosis ⬭ GERD/Reflux ⬭ Lactose Intolerance ⬭ Stomach Ulcer
⬭ Colon Cancer ⬭ Hepatitis B ⬭ Liver Disease ⬭ Ulcerative Colitis
⬭ Colon Polyps ⬭ Hepatitis C

Pulmonary ⬭ Asthma ⬭ COPD/Emphysema ⬭ Sleep Apnea

Neurology ⬭ Dementia ⬭ Seizure Disorder ⬭ Parkinson's ⬭ Stroke

Psychiatric ⬭ Anxiety ⬭ Depression ⬭ PTSD ⬭ Alcohol Abuse Disorder

Rheumatology ⬭ Lupus (SLE) ⬭ Rheumatoid Arthritis

Urinary ⬭ Chronic Kidney Disease ⬭ Hemodialysis ⬭ Peritoneal Dialysis

Oncology ⬭ Cancer, type_____

Other Condition(s) _____

If you have Ulcerative Colitis or Crohn's Disease, please provide immunization information

⬭ None

Influenza		**Pneumococcal**		**COVID**	
Shingles		**Tdap/Td**		**Hepatitis B**	
HPV					

⬭ Last TB Screening, when? _____ ⬭ Hep B Screening, when? _____

PLEASE COMPLETE ALL PAGES - FRONT AND BACK

Diagnostic Studies/Tests ⬭ None

Have you ever had?	If not at PGA, when?	If not at PGA, where?
Colonoscopy		
Sigmoidoscopy		
EGD		
EUS		
ERCP		
Liver Biopsy		
Have you had in the last 12 mos?	**If not ordered by PGA, when?**	**If not ordered at PGA, where?**
Abdominal Ultrasound		
Abdominal CAT scan		
Abdominal MRI/MRCP		
Lab testing/Blood work		

Previous Surgery ⬭ None

Appendectomy		Nissen Fundoplication		Cardiac Stent	
Cardiac Bypass		Gallbladder Removal		Joint Replacement	
Pacemaker		Heart Valve Replacement		Defibrillator	
C-Section		Hemorrhoidectomy			

⬭ Bowel Surgery or resection, type and when? _____

⬭ Hernia Repair, type and when? _____

Family Gastrointestinal Medical History ⬭ Unknown

	None	Mother	Father	Sister	Brother	Daughter	Son
Colon Cancer	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Colon Polyps	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Celiac Disease	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Gastric Cancer	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Liver Disease	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Pancreatic Cancer	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Ulcerative Colitis/Crohn's	⬭	⬭	⬭	⬭	⬭	⬭	⬭

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

⬭ Yes ⬭ No

Consent to Share Data

I consent to having my medical and non-identifying demographic information shared with other health care entities.

Example: Health data banks or Medical Registries for the purpose of research in health care trends such as the American Gastroenterology Association

⬭ Yes ⬭ No

Patient Care Reminder Preference

I would like to receive preventative care and follow up care reminders. ⬭ Yes ⬭ No

Example: Colonoscopy Recall

Care Reminder Contact Preference ⬭ Email ⬭ Patient Declines to specify ⬭ Other: _____