ASSOCIATES IN GASTROENTEROLOGY, PC
THE ENDOSCOPY CENTER OF COLORADO SPRINGS, LLC

Colorado Springs, Co. 80909 Office 719-635-7321 Endoscopy Center 719-785-3500

PATIENT INFORMATION SHEET

Name_____ Sex: F M DOB_____ Age_____ Date _____

Marital status: Single_____ Married____ Divorced____ Widowed_____ Number of Children_____

(circle MD) Van Os Lunt Howden Garza Cesario Kavanaugh Baker

Michelle Barnett, PAC Sarah Garza, NP Billie Jo Baptiste, NP Courtney Frerichs, PAC

Primary Care Physician_____Primary Care Physician's phone #_____

It is important for our physicians / PAC to have your complete health history. Please help us by taking the time to provide this information accurately and completely. This information will be a confidential part of your medical record.

PAST SURGICAL AND MEDICAL HISTORY—(Circle Yes or NO) If yes, Date of onset, comments.

MEDICAL HISTORY	YES	NO	Onset, Comments	SURGICAL HISTORY	YES	NO	Date, Comments
Anorexia / Bulemia	Yes	No		Colon	Yes	No	
Arthritis / Joint swelling	Yes	No		Stomach	Yes	No	
Asthma	Yes	No		**Heart:**	Yes	No	
Bleeding disorder	Yes	No		Stent / Bypass	Yes	No	
Blood or infectious disease	Yes	No		Valve	Yes	No	
Cancer, Type:	Yes	No		Pacemaker	Yes	No	
Colon polyps	Yes	No		Defibrillator	Yes	No	
Crohn's disease	Yes	No		Joint replacement	Yes	No	
Diabetes	Yes	No		Gallbladder	Yes	No	
Epilepsy / seizures	Yes	No		Hysterectomy	Yes	No	
Gallstones	Yes	No		Appendix	Yes	No	
Glaucoma	Yes	No		Prostate	Yes	No	
Headaches/ fainting/ dizziness	Yes	No		Bladder	Yes	No	
Heart problems/ Chest pain	Yes	No		C-section	Yes	No	
Hepatitis / Liver problems	Yes	No		Breast	Yes	No	
Hiatal hernia / GERD	Yes	No		Other surgeries			
High / low Blood pressure	Yes	No		Other surgeries			
Kidney disease	Yes	No		Other surgeries			
Lung Disease	Yes	No		Other surgeries			
Pacemaker / Internal defibrillator	Yes	No		Anesthesia Problems	Yes	No	
Sleep Apnea	Yes	No		Previous EGD	Yes	No	
Stomach problems / ulcers	Yes	No		Prev Colonoscopy	Yes	No	
Stroke	Yes	No		**Vaccinations (yes or No, and date)**			
Thyroid problems	Yes	No		Hepatitis A	Yes	No	
Tuberculosis	Yes	No		Hepatitis B	Yes	No	
Ulcerative Colitis	Yes	No					
Other							
Other							
Other							

SOCIAL HISTORY: (Past or Current)

Alcohol	Yes	No	Quit	Duration & Amount
Coffee / Caffeine	Yes	No	Quit	Duration & Amount
Substance Abuse	Yes	No	Quit	Duration & Amount
Tobacco	Yes	No	Quit	Duration & Amount
Blood Transfusions	Yes	No	When?	
Tattoos	Yes	No		
Do you exercise?	Yes	No	How much?	

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Patient Name:_____

FAMILY HISTORY: Please indicate any **RELATIVES** with the following diseases.

Alcoholism	Yes	No		Celiac disease	Yes	No	
Cirrhosis / Jaundice	Yes	No		Gallstones	Yes	No	
Colon Cancer	Yes	No		Hemachromatosis	Yes	No	
Colon or rectal polyps	Yes	No		Heart disease	Yes	No	
Crohn's/Ulcerative Colitis	Yes	No		High Blood Pressure	Yes	No	
Diabetes	Yes	No		Liver Disease	Yes	No	

SYMPTOM REVIEW Check (☒) symptoms you currently have or have had in the past

☐ Weight Loss	☐ Cough	☐ Frequent urination	☐ Memory loss
☐ Fever/Chills	☐ Shortness of breath	☐ Incontinence of urine	☐ Depression
☐ Poor vision/double vision	☐ Heart burn	☐ Difficulty urinating	☐ Anxiety
☐ Dry mouth	☐ Nausea / vomiting	☐ Blood in urine	☐ Hair loss
☐ Frequent nosebleeds	☐ Swallowing difficulties	☐ Arthritis/Joint pain	☐ Hot/Cold sensitivity
☐ Hearing loss	☐ Pain with swallowing	☐ Muscle aches	☐ Excessive thirst
☐ Nasal congestion	☐ Abdominal pain	☐ New or chronic rash	☐ Easy bruising
☐ Hoarseness	☐ Diarrhea	☐ Nail changes	☐ Excessive bleeding
☐ Chest pain	☐ Constipation	☐ Headaches	☐ Swollen lymph nodes
☐ Irregular heart beat	☐ Blood in stool	☐ Seizures	☐ Swelling of ankles/legs

Other:

Other:

Other Physicians Who Are Actively Treating You:

Physician:	**Condition:**	**Physician:**	Condition:
Physician:	**Condition:**	**Physician:**	Condition:
Physician:	**Condition:**	**Physician:**	Condition:
Physician:	**Condition:**	**Physician:**	Condition:

My_____(family member**), _____(**name**) has been treated by this same Gastroenterologist.**

Continue with medication list on page 3

DO NOT WRITE BELOW THIS LINE. PHYSICIAN AREA ONLY

History Reviewed by:

If this form was filled out more than 30 days ago patient and physician will review and update:

Updated_____Patient Signature:_____ Physician sig:_____
Updated_____Patient Signature:_____ Physician sig:_____
Updated_____Patient Signature:_____ Physician sig:_____
Updated_____Patient Signature:_____ Physician sig:_____
Updated_____Patient Signature:_____ Physician sig:_____

Patient Label:

Associates in Gastroenterology, P.C
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2940 N. Circle Dr. Colorado Springs, CO 80909

Endoscopy Center of Colorado Springs
Endoscopy Center
719-785-3500
www.agcosprings.com

Name_____ Sex: F M DOB_____ Age_____ Date _____

Allergy/Intolerance	Reaction(s)	Allergy/Intolerance	Reaction(s)	Allergy/Intolerance	Reaction(s)
☐ No known medication allergies					

MEDICATION LIST

[List all **MEDICATIONS (Over the counter and prescriptions), NUTRITIONALS, HERBAL SUPPLEMENTS, AND PUMPS AND PATCHES**]

Medication	Amount (Dose) Route, Frequency	Do not write past this column—physician area	Resume Meds at Discharge								
			Date		RESTART DATE	Date		RESTART DATE	Date		RESTART DATE
Example: Name of medication	25 mg 1 x per day		Yes	No		Yes	No		Yes	No	
Copy given to patient upon discharge / Check box ☐ plus initials			☐			☐			☐		

Based on your visit to Associates in Gastroenterology or the Endoscopy Center of Colorado Springs, you may safely continue the medications indicated above. Restart date for medications stopped is indicated in the column on the right.

Ordering Physician/PA MD/PA_____ DATE:_____
MD/PA_____ DATE:_____
MD/PA_____ DATE:_____

PRESCRIPTIONS GIVEN AT DISCHARGE

Medication	Dose / Route/ Frequency	Indication	Start Date

Patient Label