West Chester Gastrointestinal Group

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PATIENT QUESTIONNAIRE

LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX (JR, SR, III)

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL:

DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	GENDER

MARITAL STATUS	SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH

NAMES AND AGES OF OTHERS LIVING WITH YOU:

EMPLOYER ☐ RETIRED ☐ STUDENT ☐ OTHER	OCCUPATION

REFERRING PHYSICIAN	FAMILY PHYSICIAN/PHONE:

EMERGENCY CONTACT NAME:	PHONE NUMBER(S):

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino	RACE: ☐ Asian ☐ Black ☐ Hispanic ☐ Caucasian ☐ Two or more groups ☐ Unknown ☐ Other LANGUAGE:

HOW DID YOU HEAR ABOUT OUR OFFICE? (please check ALL that apply)

[ ] OUR WEBSITE	[ ] INTERNET SEARCH	[ ] CHESTER COUNTY HOSPITAL WEBSITE
[ ] NEWSPAPER ADVERTISEMENT	[ ] OTHER ADVERTISEMENT	[ ] RADIO
[ ] FROM A FRIEND/FAMILY	[ ] YELLOW PAGES	[ ] OTHER (PLEASE SPECIFY):

Insurance Company

Insurance Company Name:

Secondary Insurance Company:

If your insurance requires referrals, it is your responsibility to contact your primary care physician's office staff to have these issued prior to your appointment. Some offices require 2 to 3 days notice, so do not wait until the last minute. IF YOU DO NOT HAVE A REFERRAL FOR YOUR VISIT, YOU MAY BE FINANCIALLY RESPONSIBLE OR BE REQUIRED TO RESCHEDULE YOUR APPOINTMENT. I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to be paid directly to West Chester G.I. Associates, P.C. and West Chester Endoscopy, L.L.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

By my signature below, I hereby acknowledge receipt of the West Chester G.I. Associates, P.C. Financial Policy:

Patient Name (print) **Patient Signature** **Date**

FOR OFFICE USE ONLY:			
Demographics entered/verified:	DATE:	Physician Review:	DATE:

MEDICAL QUESTIONNAIRE

Reason You Were Referred and/or Major Digestive Complaint:

Past Medical History: Medical Illness						
1. Heart disease	Yes	No	7. Cancer	Yes	No	Type
2. Heart attack	Yes	No	8. Stroke or neurological disease	Yes	No	
3. High blood pressure	Yes	No	9. Blood disorder	Yes	No	
4. Diabetes	Yes	No	10. Other			
5. Lung disease	Yes	No	11. Other			
6. Kidney disease	Yes	No	12. Other			
Name of physician(s) treating any of the above:						

Past Surgical History – list operations and dates	
1.	4.
2.	5.
3.	6.

Prior Gastrointestinal or Liver Disease:					
1. Irritable bowel	Yes	No	3. Cirrhosis or hepatitis	Yes	No
2. Ulcer	Yes	No	4. Colon Cancer or Colon Polyps	Yes	No
5. Other:					
Have you ever seen a gastroenterologist?			Yes No		
Name and address:					

Prior Gastrointestinal X-rays/Colonoscopy/Endoscopy:		
1) What kind:	When:	Where:
Why:		
2) What kind:	When:	Where:
Why:		

Medications:		
1.	4.	7.
2.	5.	8.
3.	6.	9.
Patient Pharmacy:	**Address:**	
Phone:		

Allergies:
To Medications:
To Intravenous dye/iodine/shellfish/latex/eggs:

Patient Name (print) **Patient Signature** **Date**

Family Medical History:	
(G.I. illnesses, stomach, liver, colon or gallbladder)	
1.	3.
2.	4. Colon Cancer or Colon Polyps Yes No

Other Family Illnesses:	
1.	3.
2.	4.

Travel & Lifestyle:
Foreign Travel in the Past Year:
Transfusions:
Tobacco Usage: What type and how many:
Alcohol Usage: What type and how many:
Aspirin Usage; Other Arthritis Medicine:

Female Patients Only:	
Gynecologic history:	
Gynecologist:	Last Visit:
Last menstrual period (if applicable)	Present/prior birth control usage:

DO YOU NOW HAVE: (circle)
1. **General**: Not Present- Weight Gain, Weight Loss, Fever, Chills, Night Sweats and Fatigue.
2. **Skin**: Not Present- Itching, Rash and Eczema.
3. **HEENT**: Not Present – Inflammation of Eyes, Vision changes, Nose Bleed, Seasonal Allergies, Sinus Pain, Hoarseness, Sore Throat, Severe Gum or Dental disease and Sore Tongue.
4. **Respiratory**: Not Present- Wheezing, Cough and Shortness of Breath.
5. **Cardiovascular**: Not Present- Chest Pain, Palpitations, Irregular Heart Beat and Leg pain and/or Swelling.
6. **Gastrointestinal**: Not Present- Loss of Appetite, Belching, Excessive gas, Nausea, Vomiting, Regurgitation, Heartburn, Painful Swallowing, Abdominal Pain, Diarrhea, Constipation, Change in Bowel Habits, Rectal Bleeding, Vomiting Blood, Bloating, Laxative Use and Jaundice.
7. **Female Genitourinary**: Not Present- Difficulty Urinating, Frequency, Painful Urination, Incontinence, Blood in Urine, Menstrual Irregularities, Heavy Bleeding and Painful Menstruation.
8. **Male Genitourinary:** Not Present- Frequency, Painful Urination, Incontinence, Blood in Urine and Difficulty Urinating.
9. **Musculoskeletal**: Not Present- Joint Swelling, Muscle Cramps, Joint Pain and Back Pain.
10. **Neurological**: Not Present- Seizures, Headaches or Migraines, Stroke, Numbness, Tingling, Dizziness and Weakness.
11. **Psychiatric**: Not Present- Depression, Frequent Crying, Nervousness, Change in Sleep Pattern and Excessive Stress.
12. **Endocrine**: Not Present- Appetite Changes and Thyroid Problems.
13. **Hematology**: Not Present- Anemia, Abnormal Bleeding, Enlarged Lymph Nodes and Easy Bruising.

Patient Name (print) **Patient Signature** **Date**