



GASTROENTEROLOGY OF
SOUTHERN INDIANA, P.C.

**Gastroenterology
of Southern
Indiana, P.C.**

As of July 1, 2009
2630 Grant Line Road
New Albany, IN 47150
812-945-0145 ph
812-949-5435 fx



SOUTHERN INDIANA
ENDOSCOPY, LLC

**Southern Indiana
Endoscopy, LLC**

825 University Woods
Suite 2
New Albany, IN 47150
812-945-0145 ph
812-949-5443 fx

Thank you for choosing Gastroenterology of Southern Indiana and Southern Indiana Endoscopy for your digestive health. Please complete the three attached forms and then either:

1. Print them off and bring with you to your appointment
2. Print them off and fax them to the appropriate number at left
3. E-mail these forms to Alicia Prince at APrince@gsi-sie.com

If you have any questions, please feel free to call
812-945-0145.

Thank you for helping be ecologically conscious by being
paperless.

Procedure Scheduling Form

Date: _____ Doctor: _____ Account: _____

Please fill in all information listed below to assure your appointment is scheduled for your convenience and all major health issues are taken into consideration for safety of your preparation prior to the procedure.

YOU ARE SEDATED FOR THESE PROCEDURES AND WILL NEED SOMEONE TO DRIVE YOU HOME AFTERWARD.

Patient: _____ DOB: _____
 First Last

Procedure will be performed at Southern Indiana Endoscopy unless we do not participate with your insurance plan.

Schedule procedure on: Monday Tuesday Wednesday Thursday Friday Any

Is there any specific date(s) **good** for you? _____

Is there any specific date(s) **not good** for you? _____

Are you allergic to latex? yes no

Are you a diabetic? yes no
If yes, controlled by: Diet

Medicine
Name: _____

Dosage _____

Insulin - dosage _____

Do you take medications for: Arthritis _____

Heart disease _____

Blood thinner _____

Do you have an artificial heart valve? yes no
If yes, do you receive antibiotics prior to dental work or surgery? yes no

Do you have a pacemaker? Yes no
If yes, list brand and model _____

Do you have a personal history of cancer? Yes no Who/Type _____

Please be aware that if a procedure needs to be rescheduled it could take up to 4-6 weeks depending on the physicians' schedules. We appreciate and encourage that you make every effort to keep your appointment.

Patient Information Form
www.gsi-sie.com



2630 Grant Line Road
New Albany, IN 47150
PHONE 812-945-0145 FAX 812-949-5435

ACCOUNT # _____

LAST NAME:		FIRST NAME:		MI:
ADDRESS:				
CITY:		STATE:	ZIP CODE:	
DATE OF BIRTH:	SOCIAL SECURITY #:		SEX:	MARITAL STATUS:
PHONE NUMBERS: HOME		WORK	CELL	
EMAIL ADDRESS:		CAN WE CONTACT YOU BY EMAIL?		
EMPLOYER:				
SPOUSE/PARTNER:			DATE OF BIRTH	
EMERGENCY CONTACT NAME:		RELATION:	PHONE:	
PRIMARY CARE PHYSICIAN:			REFERRING PHYSICIAN:	

PRIMARY INSURANCE:				
ADDRESS:				
POLICY NUMBER:		GROUP NUMBER:		
PHONE:	COPAY:	EFFECTIVE DATE:		
POLICY HOLDER NAME:		DATE OF BIRTH:		
EMPLOYER:				

SECONDARY INSURANCE:				
ADDRESS:				
POLICY NUMBER:		GROUP NUMBER:		
PHONE:	COPAY:	EFFECTIVE DATE:		
POLICY HOLDER NAME:		DATE OF BIRTH:		
EMPLOYER:				

INSURANCE AUTHORIZATION:

I request that payment of authorized benefits be made either to me or on my behalf to the above provider for services furnished by that physician. I authorize release to the indicated insurance carrier any medical information about me needed to determine these payments for related services. I understand that I am responsible for all fees regardless of insurance.

SIGNATURE:	DATE:
-------------------	--------------



2630 Grant Line Road
New Albany, IN 47150
(812)945-0145

Patient Interview Form

Patient Information

First Name: _____ Last Name: _____
MRN: _____ Date Of Birth: _____

Race

- White/Caucasian Black or African American Asian Hispanic or Latino American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander Mixed Other Unknown Patient declines to provide information
 Prohibited by state law

Ethnicity

- Hispanic or Latino Not Hispanic or Latino Patient declines to provide information Prohibited by state law

Preferred Language

Other: _____

Allergies

- Patient has no known allergies Patient has no known drug allergies
 Aspirin Iodine Penicillins Sulfa (Sulfonamides) Versed
 Dairy products Latex codeine sulfate Other: _____

Current Medications

- None

Name	Dose	How taken?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy

Name: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- Single Married Divorced Separated Widowed
 Civil Union Unknown Other

Alcohol

None

Type	Quantity	Frequency
<input type="radio"/> Alcoholic Drink	_____	Times / week

Caffeine

None

Tobacco

- Smoking Status** Current every day smoker Current some day smoker Former smoker Never smoker
 Smoker, current status unknown Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
<input type="radio"/> Cigarettes	_____	_____	_____	Cigarettes / Day

Drug Use

None

Type	Quantity	Frequency
<input type="radio"/> Recreational Drugs	_____	Times / week

Exercise

None

Previous Procedures

None

- | | | | | |
|---|--|---|---|---|
| <input type="radio"/> Appendectomy | <input type="radio"/> Capsule Endoscopy | <input type="radio"/> Cardiac (CABG) | <input type="radio"/> Cardiac (VALVE) | <input type="radio"/> Colon Polyp Removal |
| <input type="radio"/> Colon Resection | <input type="radio"/> Colonoscopy | <input type="radio"/> Colostomy | <input type="radio"/> C-Section | <input type="radio"/> ERCP |
| <input type="radio"/> Gallbladder | <input type="radio"/> Groin Hernia | <input type="radio"/> Hemorrhoid | <input type="radio"/> Hiatal Hernia | <input type="radio"/> Hysterectomy |
| <input type="radio"/> Joint Replacement | <input type="radio"/> Kidney | <input type="radio"/> Liver Biopsy | <input type="radio"/> Obesity Surgery | <input type="radio"/> Ovary surgery |
| <input type="radio"/> Pacemaker/Defibrillator | <input type="radio"/> Prostate Surgery | <input type="radio"/> Radiation Therapy-Abdomen | <input type="radio"/> Radiation Therapy-Chest | <input type="radio"/> Radiation Therapy-Head/Neck |
| <input type="radio"/> Radiation Therapy-Ovary | <input type="radio"/> Radiation Therapy-Prostate | <input type="radio"/> Stomach | <input type="radio"/> Thyroid | <input type="radio"/> Tubal Ligation |
| <input type="radio"/> Upper/EGD | <input type="radio"/> Heart Stent Placement | <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Dialysis | Other: _____ |

Past or Present Medical Conditions

None

GI Related Illnesses

- | | | | |
|--|------------------------------------|--|--|
| <input type="radio"/> Cirrhosis | <input type="radio"/> Colon polyps | <input type="radio"/> Crohn's Disease | <input type="radio"/> Diverticulitis |
| <input type="radio"/> Esophagitis/GERD | <input type="radio"/> Gallstones | <input type="radio"/> Groin Hernia | <input type="radio"/> Hepatitis |
| <input type="radio"/> Irritable Bowel | <input type="radio"/> Pancreatitis | <input type="radio"/> Stomach/Duodenum Ulcer | <input type="radio"/> Ulcerative Colitis |

Other: _____

Other Illnesses

- | | | | |
|---|--|--|---|
| <input type="radio"/> Abnormal Bleeding | <input type="radio"/> Abnormal Blood Clotting/Blood Clots | <input type="radio"/> Anemia | <input type="radio"/> Arterial Blockages |
| <input type="radio"/> Asthma | <input type="radio"/> Blood Transfusions | <input type="radio"/> Breast cancer | <input type="radio"/> Chronic Headache |
| <input type="radio"/> Chronic Pain for less than 6 months | <input type="radio"/> Colon cancer | <input type="radio"/> Diabetes Mellitus | <input type="radio"/> Emphysema |
| <input type="radio"/> Endometriosis | <input type="radio"/> Fibromyalgia | <input type="radio"/> Frequent Urinary Infections | <input type="radio"/> Heart Disease |
| <input type="radio"/> Heart Failure | <input type="radio"/> Heart Murmurs | <input type="radio"/> High Blood Pressure | <input type="radio"/> High Cholesterol |
| <input type="radio"/> HIV/AIDS | <input type="radio"/> Irregular Heart Beat | <input type="radio"/> Kidney Disease/Failure | <input type="radio"/> kidney stones |
| <input type="radio"/> Lupus | <input type="radio"/> Melanoma | <input type="radio"/> Multiple Sclerosis | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Ovarian Cancer | <input type="radio"/> Ovarian Cyst | <input type="radio"/> Parkinson's Disease | <input type="radio"/> Pneumonia |
| <input type="radio"/> Prostate Cancer | <input type="radio"/> Psoriasis | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Seizures |
| <input type="radio"/> Sexually Transmitted Disease | <input type="radio"/> Sleep apnea | <input type="radio"/> Stroke or Paralysis | <input type="radio"/> TB or Positive TB Skin Test |
| <input type="radio"/> Thyroid Disease | <input type="radio"/> Deep vein thrombosis (blood clot in leg) | <input type="radio"/> Pulmonary embolus (blood clot in lung) | <input type="radio"/> CVA (stroke) |
| <input type="radio"/> TIA | Other: _____ | | |

Diagnostic Studies/Tests

None

Labs

Xray/Radiology

When: _____

When: _____

Immunizations

- None
 Flu vaccine
 Hepatitis A
 Hepatitis B
 HPV
 Meningococcal
 Pneumococcal
 Tdap

Family Medical History

- No knowledge of family history
 No family history of Colon cancer
 Colon Polyps

Health Status	Mother	Father	Sister	Brother	Daughter	Son
Age/Date of Birth						
Family Hx of Colon Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Colon Polyps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Celiac Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Crohn's Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Liver Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Breast Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Esophageal Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Ovarian Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Pancreatic Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Stomach Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Hx of Uterine Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Review Of Systems

Cardiovascular	Yes No	Genitourinary	Yes No
ankle swelling	<input type="radio"/>	blood in urine	<input type="radio"/>
chest pain	<input type="radio"/>	burning urination	<input type="radio"/>
irregular heart beat	<input type="radio"/>		
shortness of breath	<input type="radio"/>	Hematologic/Lymphatic	Yes No
		easy bruising	<input type="radio"/>
Constitutional	Yes No	prolonged bleeding	<input type="radio"/>
fatigue	<input type="radio"/>	abnormal blood clotting	<input type="radio"/>
fever	<input type="radio"/>		
loss of appetite	<input type="radio"/>	Integumentary	Yes No
weight loss	<input type="radio"/>	itching	<input type="radio"/>
weight gain	<input type="radio"/>	jaundice	<input type="radio"/>
		rash	<input type="radio"/>
ENMT	Yes No	suspicious lesions	<input type="radio"/>
hearing loss	<input type="radio"/>		
hoarseness	<input type="radio"/>	Musculoskeletal	Yes No
sore throat	<input type="radio"/>	back pain	<input type="radio"/>
nose bleeds	<input type="radio"/>	joint pain	<input type="radio"/>
		muscle pain	<input type="radio"/>
Endocrine	Yes No		
excessive thirst	<input type="radio"/>	Neurological	Yes No
cold intolerance	<input type="radio"/>	dizziness	<input type="radio"/>
heat intolerance	<input type="radio"/>	fainting	<input type="radio"/>
		frequent headaches	<input type="radio"/>
Eyes	Yes No	loss of consciousness	<input type="radio"/>
light sensitivity	<input type="radio"/>		
eye pain	<input type="radio"/>	Psychiatric	Yes No
visual decline	<input type="radio"/>	anxiety/panic	<input type="radio"/>
		depression	<input type="radio"/>
Gastrointestinal	Yes No	difficulty sleeping	<input type="radio"/>
abdominal pain	<input type="radio"/>		
belching	<input type="radio"/>	Respiratory	Yes No
black stools	<input type="radio"/>	coughing blood	<input type="radio"/>
bloating	<input type="radio"/>	chronic cough	<input type="radio"/>
change in bowel habits	<input type="radio"/>	painful breathing	<input type="radio"/>
constipation	<input type="radio"/>		
dairy incontinence	<input type="radio"/>		
diarrhea	<input type="radio"/>		
difficulty swallowing	<input type="radio"/>		
painful swallowing	<input type="radio"/>		
flatulence/rectal gas	<input type="radio"/>		
heartburn/reflux	<input type="radio"/>		
mucous in stools	<input type="radio"/>		
nausea	<input type="radio"/>		
painful stools	<input type="radio"/>		
rectal protusions	<input type="radio"/>		
rectal urgency	<input type="radio"/>		
soiling/incontinence	<input type="radio"/>		
vomiting	<input type="radio"/>		