East Alabama Health
EAST ALABAMA MEDICAL CENTER
GASTROENTEROLOGY CENTER

Gastroenterology Center of EAMC
New Patient Paperwork

Hello: _____

Welcome to Gastroenterology Center of EAMC,

Thank you for allowing our practice to serve you. As part of our efforts to save time during your first visit, we have enclosed our New Patient Intake Packet. Please complete this packet and bring it with you to your first visit. You will also want to bring your insurance cards, (this includes medical AND pharmacy/prescription cards), and a photo ID.

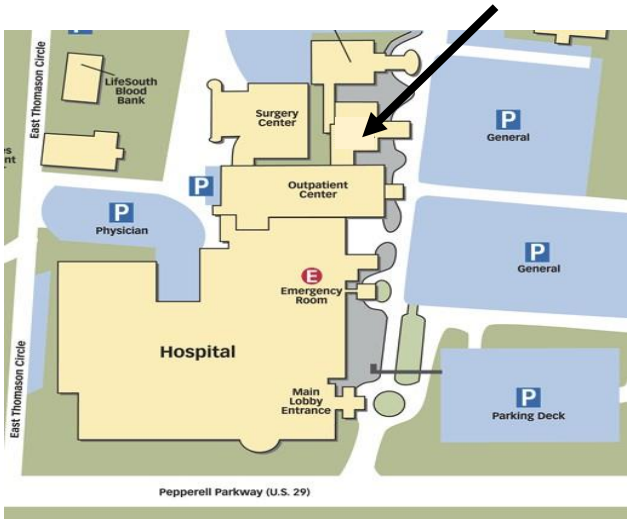
We look forward to seeing you on _____.
Please arrive 20 minutes prior to your scheduled appointment time. If you arrive 10 minutes or more after your appointment time, we reserve the right to reschedule your appointment.

If you cannot make it to your appointment, please notify us at least 24 hours before your appointment. Please note, same day cancellations are considered the same as a no-show. If you have two no-shows, it is at the provider's discretion on whether your appointment will be rescheduled. We reserve the right to charge you for missed appointments or cancellations without notice. If you do not show or call in advance, at least 24 hours, you may be charged up to $50.00.

Thank you,

Gastroenterology Center of EAMC Staff

Gastroenterology Center of EAMC is located at East Alabama Medical Center in Canopy 4.



Name: _____ **DOB**: _____ **SSN**: _____ - ____ - _____
Address: _____
Phone: **Home** (____) _____ **Work**: (____) _____ **Cell**: (____) _____
Insurance: _____ **Policy #**: _____ **Group #**: _____
2nd Insurance: _____ **Policy #**: _____ **Group #**: _____
Primary Care Provider/Clinic: _____
Local Pharmacy Name/Address: _____
Pharmacy Phone # (____) _____ **Pharmacy Fax** # (____) _____
Allergies: _____
Emergency Contact: _____ **Phone #**: _____

Reason why you are here to see the gastroenterologist? Please briefly describe your symptoms.

When did your symptoms begin?

Have you seen a gastroenterologist in the past? If so, who? What diagnosis was this doctor treating you for?

Please list any previous treatment you have received for this problem?

Please Check (✓) Any Past Illness You Have Had:

	Anxiety		Gout		Liver Disease		Rheumatoid Arthritis
	Asthma		Heart Disease		Lung Disease		Seasonal Allergies
	Bleeding Tendency		Heart Failure		Migraine Headache		Seizures
	Cholesterol (High or Low)		Hepatitis/Type _____		Neuropathy		Sleep Apnea
	COPD		High Blood Pressure		Osteoarthritis		Stroke
	Degenerative Arthritis		HIV/AIDS		Osteoporosis		Thyroid Problems
	Depression		Jaundice		Psoriasis		Tuberculosis
	Fibromyalgia		Kidney Disease		Reflux (Heartburn)		Vein Trouble
	Glaucoma		Kidney Stones		Rheumatic Fever		

DIABETES (if yes, how long & Type) _____ **CANCER** (if yes, where) _____

Other Illnesses: Please list any other medical conditions that you are being treated for?

Past Surgical/Injuries (Date & Physician): _____
_____

Drug Allergies (**also list reactions**): _____

MEDICATIONS: Please list any medications including supplements that you are currently taking (or bring a list with you). Please include: Name/Dose/How It's Taken

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

SOCIAL HISTORY:

□ Single □ Married □ Divorced □ Widowed Living with: _____

Smoking: Y or N Packs a day __ How long ___ Circle Type: (pipe, cigar, cigarettes, chew, e-cigarette)

Recently quit _____ Wants to quit _____ Never Smoked _____

Alcohol: Y or N Drinks/day average _____ Circle Type: (beer, wine, liquor)

Substance abuse: Y or N List type of drug used: _____

Occupation: _____ **Religion**: _____

Caffeine: Y or N Drinks/day average _____ Circle Type: (tea, coffee, sodas, medicine, foods)

Hobbies: _____

Diet: Y or N If yes, Circle Method of Diet: Low Carb, Low Calorie, Low Fat, Vegetarian, Other: _____

Exercise: Y or N Frequency _____ Duration _____ Type _____

FAMILY HISTORY: Please check where appropriate

Father: Alive? Y or N Illnesses: _____ Age at death: ___ Cause _____
Mother: Alive? Y or N Illnesses: _____ Age at death: ___ Cause _____
Brother/Sister-Health Issues: _____
Son/Daughter-Health Issues: _____
Other Relatives Health Issues: _____

Immunizations & Dates

Pneumovax: _____ **Hepatitis B: _____** **Measles: _____** **Gardisil: _____** **Rubella: _____**
Meningococcal: _____ **Influenza: _____** **Tetanus: _____** **Zostavax: _____**

Review of Systems – Please circle any symptoms that pertain to you:

Constitutional:	fever / chills / fatigue / night-sweats / weight change / anorexia / insomnia
Eyes:	blurry vision / dry eyes / visual loss / tearing / redness / pain / glasses / contacts
Ears/Nose/Mouth/Throat:	decreased hearing / runny nose / mouth sores / sore throat / dental pain
Cardiovascular:	chest pain / palpitations / decreased exercise tolerance / racing heart
Respiratory:	cough / shortness of breath / wheezing / painful breathing / none
Gastrointestinal:	nausea / vomiting / diarrhea / heart burn / difficulty or painful swallowing / constipation / blood in stool / hemorrhoid problems / abdominal pain
Musculoskeletal:	joint pain or swelling / weakness
Dermatologic:	rashes / jaundice / dry skin / discoloration of hands with cold exposure / sun sensitivity
Neurologic:	numbness / tingling / headaches / weakness / carpal tunnel / frequent falls / difficulty speaking / difficulty walking / decreased sensation
Psychiatric:	depression / anxiety / difficulty sleeping
Hematologic:	anemia / easy bruising

Signature: _____ **Date**: _____