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.

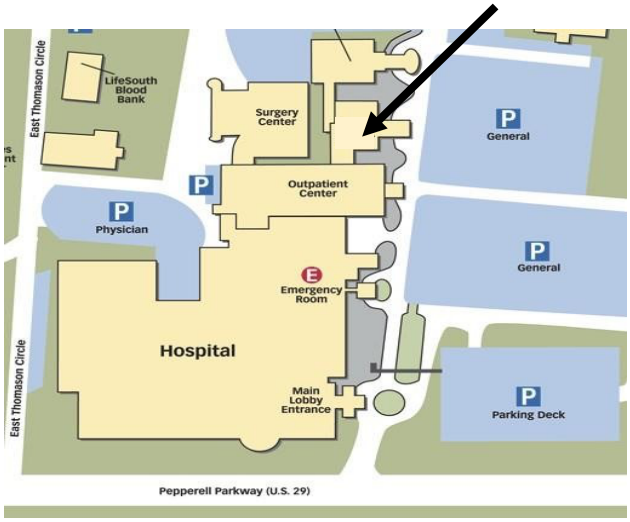
We look forward to seeing you on _____.
Please arrive 20 minutes prior to your scheduled appointment time. If you arrive 10 minutes or more after your appointment time, we reserve the right to reschedule your appointment.

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.



Gastroenterology Center of EAMC · 2000 Pepperell Parkway, Canopy 4 · Opelika, AL 36801
Phone: (334) 528-6655 · Fax: (334) 528-6657 ·

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

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, or Widowed? _____Living with: _____

Smoking: Yes, or No? _____ Packs a day _____ How long _____

Type: pipe, cigar, cigarettes, chew, and/or e- cigarettes? _____

Mark **x** next to answer: Recently quit _____ Wants to quit _____ Never Smoked _____

Alcohol: Yes, or no? _____ Drinks/day average _____

Beer, wine, and/or liquor (list all): _____

Substance abuse: Yes, or No? _____ List type of drug used: _____

Occupation: _____ **Religion**: _____

Caffeine: Yes, or no? _____ Drinks/day average _____

Tea, coffee, sodas, medicine, and/or foods (list all) _____

Hobbies:

Diet: Yes, or no? _____

Low Carb ☐

Low Calorie ☐

Low Fat ☐

Vegetarian ☐

☐ Other: _____

Exercise: Yes, or no? _____

Frequency _____

Duration _____

Type _____

FAMILY HISTORY:

Father: Alive? Yes, or no? ____ Illnesses: _____ Age at death: _____ Cause _____
Mother: Alive? Yes, or no? ____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 type an 'x' in the blank for 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**: ____________________________