Troy Gastroenterology, P.C.

Center for Digestive Health, Macomb Endoscopy Center, and Surgical Centers of Michigan

GENERAL PATIENT INFORMATION

Please complete the following form and bring it with you on the day of your scheduled appointment.

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone #: ☐ Home ☐ Cell ☐ Work ☐ Other: (____) _____ Can we leave voicemail? ☐ YES ☐ NO

Alternate Phone #: ☐ Home ☐ Cell ☐ Work ☐ Other: (____) _____ Can we leave voicemail? ☐ YES ☐ NO

Email: _____ Last 4 Digits of Social Security #: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced

Race: ☐ Caucasian ☐ African American ☐ American Indian/Alaska Native
☐ Chinese/Japanese/Korean ☐ Filipino ☐ Multiracial
☐ Pacific Islander ☐ Other _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Other _____

Language: ☐ English ☐ Arabic ☐ Japanese/Chinese/Vietnamese
☐ Korean ☐ Polish ☐ Spanish
☐ Hindi ☐ German ☐ French
☐ Greek ☐ Mandarin ☐ Romanian
☐ Other _____

PATIENT EMPLOYMENT

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Other

Employer: _____ Phone#: _____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber Name: _____

Relationship to Patient: _____ Date of Birth: _____

Secondary Insurance: _____ Subscriber Name: _____

Relationship to Patient: _____ Date of Birth: _____

MEDICAL INFORMATION-PATIENT HISTORY

MEDICATIONS: Please list all current prescriptions and over the counter medications.
☐ Check box if you have multiple medications and attach list.

MEDICATION NAME DOSE FREQUENCY

_____
_____
_____

ALLERGIES: ☐ Check box if you have multiple medication allergies and attach list.

Drug Allergies

_____ _____
_____ _____
_____ _____

Check if allergic to:
☐ **dairy** ☐ **iodine/shellfish/ IVP dye**
☐ **seasonal/ environmental**
☐ **other** _____

MEDICAL HISTORY: Please check to indicate if you have any history of the following disorders.

☐ Emphysema	☐ Liver Disease	☐ High Cholesterol	☐ Kidney Failure/Dialysis	
☐ Pneumonia/ Bronchitis	☐ Hepatitis/ HIV	☐ High Blood Pressure	☐ Seizure	
☐ Arthritis	☐ Ulcer	☐ Irregular Pulse	☐ Stroke	☐ Colon Polyps
☐ Depression	☐ Crohns	☐ Pacemaker/Defibrillator	☐ Glaucoma	☐ Learning Disabilities
☐ Anemia	☐ Pancreatitis	☐ Congestive Heart Failure	☐ Thyroid	☐ Physical Limitations
☐ Blood Transfusion	☐ IBS	☐ Heart Murmur	☐ Diabetes	
☐ Blood Disorder	☐ Ulcerative Colitis	☐ Chest Pain	☐ Hypoglycemia	
	☐ Weight Loss	☐ Heart Problems: _____	☐ Cancer:_____	

Please list any other major illness: _____

SURGICAL HISTORY: Please check to indicate if you have any history of the following operations:

☐ Colostomy ☐ Ileostomy ☐ Gastric Bypass/ Banding ☐ Joint replacement ☐ Metal implant ☐ IV Port
☐ Filters ☐ Stents (biliary cardiac, colon) ☐ Pacemaker ☐ Defibrillator

Please list all major operations: _____

Have you ever had? ☐Colonoscopy ☐EGD ☐ Upper GI ☐ Barium Enema ☐ Ultrasound ☐ Abdominal CT/ MRI

If yes, where? List Facility/Physician/Hospital: _____

SOCIAL: Please indicate your consumption of the following as they are important to GI disorders.

	DO YOU CONSUME?	HOW OFTEN?	AMOUNT
Alcohol	☐ Yes ☐ No	_____	_____
Nicotine	☐ Yes ☐ No	_____	_____
Caffeine	☐ Yes ☐ No	_____	_____
Recreational Drugs (Marijuana, cocaine,etc.)	☐ Yes ☐ No	_____	_____
	DO YOU EXPERIENCE?		
Domestic Violence	☐ Yes ☐ No	_____	_____

FAMILY HISTORY: Please complete the following information for your blood relatives:

	Father	Mother	Brother(s)	Sister(s)	Other:
Deceased	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer History:					
Colon	☐	☐	☐	☐	☐
Esophageal	☐	☐	☐	☐	☐
Pancreatic	☐	☐	☐	☐	☐
Uterine/Breast	☐	☐	☐	☐	☐
Other (specify)	☐_____	☐_____	☐_____	☐_____	☐
Digestive History:					
Crohns	☐	☐	☐	☐	☐
Reflux	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐
Other (Specify)	☐_____	☐_____	☐_____	☐ _____	☐
Cardiac History:	☐_____	☐_____	☐_____	☐ _____	☐

MEDICAL INFORMATION-PATIENT HISTORY

Reason for visit:_____

Describe your symptoms:_____

Please indicate yes or no if you have any of the symptoms listed below. Do you now, or do you have a history of:

GASTROINTESTINAL

Poor appetite	☐Yes	☐No
Difficulty in swallowing	☐Yes	☐No
Heartburn	☐Yes	☐No
Nausea or vomiting	☐Yes	☐No
Bloating	☐Yes	☐No
Belching	☐Yes	☐No
Regurgitation	☐Yes	☐No
Constipation	☐Yes	☐No
Diarrhea	☐Yes	☐No
Abdominal pain	☐Yes	☐No
Changes in bowel habits	☐Yes	☐No
Rectal bleeding	☐Yes	☐No
Jaundice	☐Yes	☐No
Ulcer	☐Yes	☐No
Black, tarry stools	☐Yes	☐No

CONSTITUTIONAL

Recent weight change	☐Yes	☐No
Fever	☐Yes	☐No
Fatigue	☐Yes	☐No
Night Sweats	☐Yes	☐No
Infections/Injuries	☐Yes	☐No

EYES

Blurred vision	☐Yes	☐No
Infections/Injuries	☐Yes	☐No
Double/blurred vision	☐Yes	☐No

EARS/NOSE/MOUTH

Hearing loss	☐Yes	☐No
Ringing in ears	☐Yes	☐No
Mouth sores	☐Yes	☐No
Sore throat	☐Yes	☐No

CARDIOVASCULAR

Shortness of breath	☐Yes	☐No
Swelling of ankles/feet	☐Yes	☐No
Heart murmur	☐Yes	☐No
Irregular pulse	☐Yes	☐No

RESPIRATORY

Chronic cough	☐Yes	☐No
Spitting up blood	☐Yes	☐No
Wheezing	☐Yes	☐No

SKIN

Rash	☐Yes	☐No
Itching	☐Yes	☐No

GENITOURINARY

Burning with urination	☐Yes	☐No
Blood in urine	☐Yes	☐No
Frequent/urgent urination	☐Yes	☐No
Incontinence	☐Yes	☐No

NEUROLOGICAL

Headaches	☐Yes	☐No
Numbness	☐Yes	☐No
Disorientation	☐Yes	☐No
Weakness	☐Yes	☐No

ENDOCRINE

Heat or cold intolerance	☐Yes	☐No
Excessive thirst / urination	☐Yes	☐No

HEMATOLOGICAL

Bleeding/ /bruising	☐Yes	☐No
Swollen glands	☐Yes	☐No

MUSCULOSKELETAL

Joint/muscle pain	☐Yes	☐No
Muscle pain	☐Yes	☐No
Arm/leg weakness/ numbness	☐Yes	☐No
Back/neck pain	☐Yes	☐No

PSYCHIATRIC

Memory loss or confusion	☐Yes	☐No

To expedite prescription prior authorizations indicate if you have ever taken any of the following medications:

Medication	Yes	Dates (if known)	Medication	Yes	Dates (if known)	Medication	Yes	Dates (if known)
Aciphex			**Fibersure**			**Pepcid**		
Amitiza			**Glycolax**			**Prevacid**		
Benefiber			**Kapidex**			**Prilosec**		
Citrucel			**Kristalose**			**Protonix**		
Correctol			**Lactulose**			**Rabeprazole**		
Dexilant			**Lansoprazole**			**Ranitidine**		
Dexlansoprazole			**Lubiprostone**			**Reglan**		
Dulcolax			**Metamucil**			**Tagamet**		
Dulcolax Balance			**Metoclopramide**			**Trulance**		
Esomeprazole			**Miralax**			**Zantac**		
Ex-Lax			**Nexium**			**Zelnorm**		
Famotidine			**Omeprazole**			**Zegerid**		
Fibercon			**Pantoprazole**			**Other**		

Patient Signature:_____ Date:_____