



Which location are you at? RUSH Oak Park Lincoln Park Rush North Shore **(Please Print)**

Name: _____ DOB: ___/___/___ Today's Date: ___/___/___

Address: _____ City _____ State _____ Zip _____

Home Phone:(_____-_____-_____) Work Phone:(_____-_____-_____) _____

Email address: _____@_____._____

Name of doctor who referred you to this clinic: _____

Referring Doctor's Phone: () _____ - _____

Referring doctor's address: _____

City _____ State _____ Zip Code: _____

Current Problem

What is the main reason for your visit to the Gastroenterology clinic?

Sex: M _____ F _____ Age _____

PMHx: Have you had the following diseases or conditions? (If yes, when did it start).

	No	Yes	When		No	Yes	When
Heart Disease (heart attacks, failure, murmurs, irregular heart beats, or rheumatic heart disease)	___	___	_____	Bleeding problems	___	___	_____
High Blood Pressure	___	___	_____	Diabetes	___	___	_____
High Blood Cholesterol	___	___	_____	Thyroid Disease	___	___	_____
Anemia or blood problems	___	___	_____	Stomach Problems	___	___	_____
Lung Disease (Asthma, emphysema, tuberculosis)	___	___	_____	Gall Bladder Disease	___	___	_____
Kidney or Bladder Disease (infection, stones etc)	___	___	_____	Seizures (Epilepsy)	___	___	_____
Liver Disease (cirrhosis, hepatitis, yellow jaundice)	___	___	_____	Strokes or Paralysis	___	___	_____
Cancer	___	___	_____	Psychiatric Problems	___	___	_____
Arthritis	___	___	_____	Skin Problems	___	___	_____

Other Medical problems _____

(Continued on back of page).

Name: _____ DOB: ____/____/____

Previous Endoscopy or X-ray Procedures

	<u>Date</u>	<u>Plan</u> (Office use only)
Colonoscopy	____/____/____	_____
EGD (Barrett's screening)	____/____/____	_____
Flexible Sigmoidoscopy	____/____/____	_____
Upper GI X-ray	____/____/____	_____
Lower GI X-ray	____/____/____	_____
Small bowel follow through X-ray	____/____/____	_____
Hepatitis B Immunization	____/____/____	_____

PSHx: Previous Hospitalizations/Surgeries

<u>Year</u>	<u>Hospitalized for what?</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Does anyone in your family have/had the following?

<u>Condition</u>	<u>No</u>	<u>Yes</u>	<u>Who</u>
Asthma	_____	_____	_____
Heart Disease	_____	_____	_____
Hypertension	_____	_____	_____
Stroke	_____	_____	_____
Cancer	_____	_____	_____
Colon Polyps	_____	_____	_____
Stomach Ulcer	_____	_____	_____
Irritable (spastic) Bowel	_____	_____	_____
Ulcerative Colitis/Crohn's	_____	_____	_____
Diabetes	_____	_____	_____
Hypo/Hyperthyroid	_____	_____	_____

(Continued on the next page)

Name: _____ DOB: ____/____/____

Social History

Marital status: Married Single Widowed Divorced How many children? _____

Occupation: _____ circle: "Current" or "Previous" occupation.

Have you traveled outside the U.S. in the last year? NO Yes→Where: _____

Cigarettes? Never No, quit in _____
Yes, if yes how many packs/day _____ for how many years _____.

Do you use alcohol? No Yes, if yes how many drinks per week? _____. Date of last drink _____.

Do you exercise? No Yes, if yes what type? _____, and how often? _____.

Please continue on to the back of this page and the next two pages.....

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Review of Systems (Please check yes or no after each question).

		<u>No</u>	<u>Yes</u>
General	In the past six months have you lost over 5 lbs unexpectedly? Do you have recurrent unexplained fevers?	_____	_____
Eyes	Do you have any eye pain or experienced intermittent loss of vision?	_____	_____
Heart	Do you have chest pain that concerns you? Do you have episodes of irregular heartbeats? Are you bothered by dizzy spells?	_____	_____
Respiratory	Do you have a persistent cough? Do you get short of breath easily or wheeze? Have you ever coughed up blood?	_____	_____
GI	Do you have difficulty swallowing food or liquids? Have you noted a recent change in appetite? Have you ever vomited blood? Do you have abdominal pain that concerns you? Have you noted black or tarry bowel movements? Have you noted any change in your bowel habits?	_____	_____
Genitourinary	Do you have discomfort when you urinate? [females] Do you have any problems with your menstrual periods?	_____	_____
Muskuloskeletal	Do you have any pain or swelling in your joints?	_____	_____
Skin	Do you have any unexplained skin rashes?	_____	_____
Neurologic	Have you had a serious head injury or been knocked unconscious? Do you have any weakness or numbness in your arms or legs?	_____	_____
Psychiatric	Are you bothered by depression? Are you bothered by mood changes?	_____	_____
Endocrine	Have you become unusually thirsty recently? Do you sense room temperature differently from others?	_____	_____
Hematologic	Do you tend to bruise or bleed easily?	_____	_____
Immunologic	Do you get recurrent infections requiring antibiotics? Have you noted any occurrences of abnormal lumps or nodules in your neck, groin or elsewhere?	_____	_____

Please sign and date below, then continue on to the next two pages.

Patient's Signature
Entire Patient data base reviewed by: _____ MD Date: ____/____/____
(Doctor's signature)

Name: _____

DOB: ____/____/____

Patient Communication/Learner Assessment

1. When learning new information about your health, do you have any difficulty because of the following:

<input type="checkbox"/> I cannot hear well	<input type="checkbox"/> I cannot see well
<input type="checkbox"/> I do not speak English well	<input type="checkbox"/> I cannot read English well
<input type="checkbox"/> I have trouble remembering things	<input type="checkbox"/> No difficulties
<input type="checkbox"/> other, please specify: _____	
2. If there is someone needed to help you (e.g. act as an interpreter), please name that person: _____ Relationship to you: _____
If you need an interpreter please specify the language needed: _____
3. How do you prefer to learn?

<input type="checkbox"/> Written instructions	<input type="checkbox"/> Oral instructions	<input type="checkbox"/> Demonstrations
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4. Do you have religious or cultural beliefs you want us to consider when we are planning your care: Yes No
5. Can we leave messages regarding your health?

At your home:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Telephone#: () _____ - _____
At work:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Telephone#: () _____ - _____
On a cell phone:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Telephone#: () _____ - _____
6. Do you prefer to communicate through electronic mail (e-mail)? Yes No

Below, please list the individuals that you would like to have access to your health information and which information you would like them to have access to:

AT ANY TIME, you may revoke the right you have given the individuals listed below.

PRINT

<u>First and Last Name</u>	<u>Relationship</u>	<u>Please circle the number (1-5) for all that applies to each individual named</u>
		1. Test results (colon, EGD, X-ray, labs, etc.) 2. Sensitive information (HIV and AIDS results, Sexually transmitted disease results, Behavioral and mental health notes.) 3. Viewing of medical record 4. Billing 5. All
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In accordance with the Health Information Privacy Act passed on April 14, 2003, you must sign below to have the practices listed above take place.

Patient Signature

Date