Eau Claire
G.I. ASSOCIATES
YOUR GASTROINTESTINAL SPECIALISTS

Date: _____ Last Name: _____ First Name: _____ Middle: _____

Sex: ☐ Male ☐ Female Date of birth: _____ SSN: _____ Aliases: _____

Address: _____ _____ City: _____ State: _____ Zip _____

Home Phone: _____ Is okay to leave message at this number: ☐ Yes ☐ No

Work Phone: _____ Is okay to leave message at this number: ☐ Yes ☐ No

Mobile: _____ Is okay to leave message at this number: ☐ Yes ☐ No

Email: _____

Preferred Communication: _____ Best time to call: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Widowed ☐ Divorced ☐ Legally Separated

Preferred Language: _____ Ethnicity: _____ Race: _____

Primary Care Physician: _____ Who referred you to our office: _____

Patient Employer: _____ Employment Status: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Employer Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Who is financially responsible for this account: _____ Relationship: _____

Insurance Information: ☐ Insurance card presented and scanned upon check-in. No need to complete this section

Name of Primary Insurance Plan: _____

Subscriber's Name: _____ Subscriber's date of birth: _____

Subscriber ID: _____ Group Number: _____

Copay: _____

Name of Secondary Insurance Plan: _____

Subscriber's Name: _____ Subscriber's date of birth: _____

Subscriber ID: _____ Group Number: _____

Copay: _____

Allergies: ☐ No known drug allergies List allergies : _____

Medications Name:	Medication Dose:	Medication Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

☐ Additional page attached for medications

Eau Claire GI Associates, SC

Social history: Check all that apply

Smoking Status: □ Current every day smoker □ current some days smoker □ Former Smoker □ Heavy tobacco smoker □ Light tobacco smoker □ Never a smoker

Start date: _____ Quit date: _____ Tobacco years: _____

Type: □ Cigarettes Packs/day _____ □ Cigars □ Pipe □ Smokeless / Electronic Cigarettes

Alcohol Use: □ Yes □ No

Drinks/week: Glasses of wine ____ Cans of beer ____ Shots of liquor_____ Standard Drinks_____

Drug Use: □ Yes -- currently using □ Yes -- history of using □ No - never used

Drug type(s): □ Marijuana □ Intravenous drugs □ Cocaine □ Methamphetamines □ Heroin □ Ecstasy

□ Other drug use _____ Drug use per week: _____

Family History: □ No knowledge of family history

Mother □ Alive, age _____ □ Deceased Present health or cause of death_____

Father □ Alive, age _____ □ Deceased Present health or cause of death_____

Brother(s) □ Alive ___ □ Deceased ____ Present health or cause of death_____

Sister(s) □ Alive ___ □ Deceased ____ Present health or cause of death_____

Child /Children □ Alive ___ □ Deceased ___ Present health or cause of death_____

Any family history of the following conditions in any blood relatives:

□ Colon polyps □ Colitis □ Liver Cancer □ Colon Cancer □ Stomach Cancer □ Pancreatic Cancer

□ Celiac Disease □ Autoimmune disease □ Bleeding/Clotting disorder □ Liver disease □ Kidney disease

□ Diabetes □ Heart Disease □ Stroke □ High blood pressure

Surgical History — Check all that apply and indicate date or □ None

□ Colonoscopy _____ □ Upper Endoscopy _____ □ Appendectomy _____

□ Colon Resection _____ □ Gastric Bypass _____ □ Gallbladder removed _____

□ Open Heart Surgery _____ □ Coronary stent placement _____ □ Pacemaker _____

□ Joint replacement_____ □ Hernia surgery _____ □ Hysterectomy _____

□ Other surgery: _____ □ Other Surgery: _____

□ Other surgery: _____ □ Other Surgery: _____

Medical History:	Check all that apply or □ None
Gastrointestinal	□ Acid Reflux □ Crohn's Disease □ Ulcerative Colitis □ Colon Cancer □ Colon Polyps □ Diverticulitis/Diverticulosis □ Gastric Ulcer □ Gastritis □ Hepatitis B □ IBS □ Cirrhosis □ Hepatitis C □ Hemorrhoids □ Celiac Disease □ Gallstones □ Pancreatitis
Cardiovascular	□ Arrhythmia □ Congestive Heart Failure □ High blood pressure □ Heart Attack □ High cholesterol □ Pacemaker
Pulmonary	□ Asthma □ COPD □ Sleep Apnea □ Emphysema
Musculoskeletal	□ Rheumatoid Arthritis □ Osteoarthritis □ Spine Disease □ Multiple Sclerosis
Endocrine	□ Diabetes Type 1 □ Diabetes Type II □ Thyroid disorder
Hematological	□ Anemia □ Bleeding problems □ Hemochromatosis
Neuropsychiatric	□ Stroke or Paralysis □ Depression □ Seizures □ Anxiety □ Bipolar Disorder □ Parkinson's
Other	□ _____ □ _____ □ _____