Olathe HEALTH
GI Specialists

20375 W. 151st Street Suite 350
Olathe, KS 66061
Phone (913)393-9898 Fax (913)393-9893

(If completing this in advance, please bring with you to your appointment)

Patient Name: ____ Today's Date: _________
Home address: Street: ____
City: ______________________ State: _______ Zip: ______
Phone: ________________ Cell Phone: _________________ Work Phone: ________________
Referring Physician: __________________ Primary care physician: ______________________
Birth Date: _____________________________ Sex: M F
Marital Status: Single Married Divorced Widowed
Social Sec #: ____________________
Employment Status: ______________ Employer: ________________________________

Emergency Contact: _________________________ Relationship___________________________
Home Phone: _____________________________ Work Phone: _______________________

Primary Insurance Name: _____________________________________
Policy # ______________________________ Group #:________________________________
Subscriber name: _______________________ DOB:_______________ SS#_________________
Secondary Insurance Name: ___________________________________
Policy # ______________________________ Group #:________________________________
Subscriber name: _______________________ DOB:_______________ SS#_________________

Additional patient information:
Reason for your visit today: ____
Email Address: ____
Pharmacy name: _____________________ Cross street/address: ________________________
Mail order pharmacy: _____________________________

Patient name:____ Date:_________________________

Medical History-Please check all that apply to your medical history

- ☐ Hiatal Hernia
- ☐ Esophageal Spasm
- ☐ Depression
- ☐ Peptic Ulcer
- ☐ Pancreatitis
- ☐ Cirrhosis
- ☐ Gallstones
- ☐ Colon polyps
- ☐ Colon cancer
- ☐ Diverticulosis /Diverticulitis
- ☐ Crohn's/Ulcerative Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Hemorrhoids
- ☐ Lactose Intolerance
- ☐ Seizures
- ☐ Prostate Enlargement/Cancer
- ☐ Heart Valve
- ☐ Coronary Artery Disease
- ☐ Myocardial Infarction
- ☐ Atrial Fibrillation
- ☐ High Blood Pressure
- ☐ COPD
- ☐ Asthma
- ☐ Chronic Renal Failure
- ☐ Anal Fissures
- ☐ Arthritis/Gout
- ☐ Breast Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Strokes/TIA
- ☐ High Cholesterol
- ☐ Lower GI Bleeding
- ☐ GERD

Surgical History-Please check all that apply to your surgical past

- ☐ Appendectomy
- ☐ Gallbladder removal
- ☐ Hysterectomy
- ☐ Hernia
- ☐ Small Bowel Resection
- ☐ Colon Resection
- ☐ Nissen Fundoplication
- ☐ Breast Lump/Mastectomy
- ☐ Heart Bypass
- ☐ Pacemaker
- ☐ Orthopedic (knee/hip)
- ☐ Tonsillectomy
- ☐ Laparoscopy
- ☐ Prostate
- ☐ Bladder/cystocele/rectocele
- ☐ Thyroid

Family History-Please check all that apply to your family medical history

	Condition				
☐	Colon polyps/Colon Cancer	Mother	Father	Brother	Sister
☐	Gastric cancer	Mother	Father	Brother	Sister
☐	Pancreatic cancer	Mother	Father	Brother	Sister
☐	Breast Cancer	Mother	Sister		
☐	Ulcerative colitis/Crohns	Mother	Father	Brother	Sister
☐	Liver disease	Mother	Father	Brother	Sister
☐	Diabetes	Mother	Father	Brother	Sister
☐	Coronary artery disease	Mother	Father	Brother	Sister

Social History: (please circle)

Marital status: Single Married Divorced Widowed

Smoking/Tobacco Use: Quit No Yes Packs per day____________ Number of years________________

Alcohol Use : Quit No Yes If yes what type: beer l iquor wine how many drinks per day?_______

Caffeine Use Number of cups/drinks a day? ______________

Previous GI Testing- Please check all that apply to any GI workup you have had done.

- ☐ EGD
- ☐ CT Scans
- ☐ Gastric Emptying Scan
- ☐ Small Bowel Follow Thru
- ☐ Lab work
- ☐ Colonoscopy
- ☐ Abdominal/Pelvic sonograms
- ☐ Upper GI Series
- ☐ Any other tests:

Patient name:_________________________________ Date:______________________

Please indicate if you are *CURRENTLY* having any of the symptoms listed below. By not selecting a symptom you are denying having this problem at this time.

Constitutional ☐ Decrease in appetite ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weight loss ☐ Weight gain

Eyes/ENT ☐ Blurred or double vision ☐ Diminished Vision ☐ Drainage ☐ Hoarseness ☐ Hearing loss or ringing ☐ Chronic sinus problems ☐ Nose bleeds

Respiratory ☐ Chronic Cough ☐ Wheezing ☐ Shortness of breath

Endocrine ☐ Increased thirst ☐ Cold/Heat intolerance ☐ Breast Discharge ☐ Change in menstrual cycle

Cardiovascular ☐ Chest Pain ☐ Palpitations ☐ Leg Swelling ☐ Pacemaker

Hematology ☐ Coumadin treatment ☐ Nose Bleeds ☐ Easy bruising ☐ Swollen glands ☐ Anemia

Genitourinary ☐ Frequent urination ☐ Burning/painful urination ☐ Blood in urine ☐ Decreased flow

Musculoskeletal ☐ Painful joints ☐ Joint swelling ☐ Muscle cramps ☐ Back pain

Skin ☐ Itching ☐ Rash ☐ Hives ☐ Skin Cancer ☐
Dry Skin

Neurological ☐ Dizzy or light headed ☐ Epilepsy ☐ Numbness or tingling ☐ Memory loss ☐ Difficulty speaking

Psychiatric ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Stress ☐ Mood changes

Medications: List all medications you presently take.

Non-Traditional Medications Please list herbs and/or dietary supplements

Allergies: Drug/Agent Reaction

Drug/Agent	Reaction