Gastroenterology HEALTH PARTNERS

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Louisville Endoscopy Center

1. Please complete the enclosed registration forms making sure to date and sign the bottom of it.
2. Make a copy of the front **and** back of your insurance cards making note of primary and secondary insurances.
3. **If** your insurance requires a referral **YOU** must request one from your Primary Care Physician.
4. Mail the completed forms with copies of insurance to:

Louisville Endoscopy Center
Attn: Scheduling Bypass Coordinator
1400 Poplar Level Rd.
Louisville, KY. 40217
502-636-2003
Or
Fax: 502-636-4032- Scheduling Bypass Coordinator

5. Your procedure will be scheduled **AFTER** all paperwork is received. It can take up to 4 weeks to process. Once scheduled you will receive additional paperwork and appointment date & time in the mail.

Please note: You must complete these forms; leaving information blank may result in a delay to scheduling your appointment and returned paperwork. We are **REQUIRED** by the state of Kentucky to collect the information on these forms, please mark the appropriate boxes. If you have had a colonoscopy by a different physician in the past, please provide us with copies of the reports as well as pathology when returning your paperwork.

You will be sedated for your procedure. You MUST arrange for someone 18 year of age or older to stay at the Endoscopy Center during your procedure and drive you home afterward.

I prefer my procedure to be on: Monday Tuesday Wednesday Thursday Friday No Preference

Do you have a physician preference from this group, if so, please list? _____

Are there any specific dates good for you? _____

Are there any specific dates NOT good for you? _____

Due to physician availability, we may not be able to accommodate the specific dates or times you have requested. However, we will work closely with you to find a time suitable for your needs.

Scheduling Bypass Coordinator 502-259-0029

PATIENT DEMOGRAPHIC INFORMATION
(Please Print)

Today's Date: ___/___/_____

Patient Name: _____

FIRST MI LAST

Date of Birth: ___/___/_____ Sex: M F SSN: _____-____-_____

Address: _____

STREET APT# CITY STATE ZIP

Cell Phone: (____)____-_____ Home Phone: (_____) _____-_____

Personal Email Address: _____

Height: _____ Weight: _____ BMI: _____

Reason for Visit: _____

Referred by: _____

Primary Care Physician: _____

Cardiologist: _____

Please Specify: WHITE/CAUCASION BLACK/AFRICAN AMERICAN HISPANIC/LATINO ASIAN OTHER: _____

Ethnicity: HISPANIC/LATINO NOT HISPANIC/LATINO PATIENT DECLINES TO PROVIDE INFORMATION

Preferred Language: _____ Marital Status: _____

EMERGENCY CONTACT & RELATIONSHIP: _____ ***PHONE:*** (____)____-_____

LOCAL PHARMACY
(address must be listed)

Name: _____

Address: _____

STREET APT# CITY STATE ZIP

Phone Number: _____

MAIL ORDER PHARMACY

Name: _____

Address: _____

STREET APT# CITY STATE ZIP

Phone Number: _____

INSURANCE INFORMATION
(Complete all information for billing purposes)

Primary: _____
INSURANCE COMPANY CERTIFICATE OR ID# GROUP#

Name of person who carries the insurance: _____ **Date of Birth:** ___/___/_____

Relationship to patient: _____ **SSN of Policy Holder:** _____-____-_____

Secondary: _____
INSURANCE COMPANY CERTIFICATE OR ID# GROUP#

Name of person who carries the insurance: _____ **Date of Birth:** ___/___/_____

Relationship to patient: _____ **SSN of Policy Holder:** _____-____-_____

Insurance Authorization and Assignment I hereby authorize Louisville Endoscopy Center to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

By signing your name you are agreeing that all the information you have disclosed is accurate.

Date: ___/___/_____ Signature:_____ Relationship: _____

PATIENT INTERVIEW FORM

Allergies – specify reaction

⬭ Patient has no known allergies		⬭ Patient has no known drug allergies		
Drug Allergies (please specify reaction)	⬭ NC aspirin	⬭ codeine sulfate	⬭ NC iodine	⬭ NC Latex
	⬭ NC lidocaine	⬭ NC Narcotics	⬭ Nsaids (Non-Steroidal Anti-Inflammatory Drug)	⬭ Penicillins
	⬭ NC propofol	⬭ Sulfa (Sulfonamide Antibiotics)	Other:	
Food Allergies (please specify reaction)	⬭ NC Eggs	⬭ NC Peanuts	⬭ NC Soy Bean	

Current Medications- if you are on a blood thinner, please list prescribing physician's name and phone number

NAME	DOSE	HOW DO YOU TAKE THIS MED? (once a day, twice a day, etc.)

Immunizations

- ☐ None
- ☐ Flu vaccine
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HPV
- ☐ Meningococcal
- ☐ Pneumonia Vaccine
- ☐ PPD
- ☐ Shingles
- ☐ Tetanus Toxoid

Diagnostic Studies/Tests

- ☐ None
- ☐ Chest xray — When:_____
- ☐ Colonoscopy — When:_____
- ☐ CT Abdomen — When:_____
- ☐ EGD — When:_____
- ☐ ERCP — When:_____
- ☐ Gastric Emptying Study — When:_____
- ☐ HIDA (Gallbladder) scan — When:_____
- ☐ MRI of Abdomen — When:_____
- ☐ Ultra Sound - Abdomen — When:_____
- ☐ X-Ray - Abdominal — When:_____

Past or Present Medical Conditions

- ☐ None

GI Related Illnesses

- ☐ Cirrhosis
- ☐ Colitis
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Crohns Disease
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ GERD/heartburn
- ☐ Hepatitis Type:_____
- ☐ Hiatal Hernia
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Stomach Ulcer
- Other:_____

Other Illnesses

- ☐ Abnormal Blood Clotting
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Ascites
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood Clot Specify where:_____
- ☐ Brain Injury
- ☐ Cancer : Type and Treatment:_____
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Endometerosis
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Irregular Heart Rate Specify:_____
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Parkinsons
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid Disorder

Other:_____

Previous Procedures

- ☐ None
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bladder Surgery
- ☐ Breast Surgery
- ☐ Cardiac Bypass How many:_____
- ☐ Cardiac stents - how many?_____
- ☐ Colon Polyp Removal
- ☐ Colon Resection
- ☐ C-Section
- ☐ Cosmetic surgery
- ☐ Defibrillator - Please specify model_____
- ☐ Dialysis
- ☐ ERCP/stent and stone extraction
- ☐ Gallbladder removed
- ☐ Heart Valve Surgery What valve?_____
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint replacement: What joint:_____
- ☐ Liver Biopsy
- ☐ Obesity Surgery Specify:_____
- ☐ Pacemaker Model/Serial Number:_____
- ☐ Prostate Surgery
- ☐ Thyroid Surgery
- ☐ Tubal Ligation

Social History

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed
- ◯ Civil Union
- ◯ Unknown
- ◯ Other

Alcohol

- ◯ None
- ◯ Social (Few times per month)
- ◯ Light (few drinks per week)
- ◯ Moderate (1 drink daily)
- ◯ Heavy (multiple drinks daily)

Tobacco

Smoking Status

- ◯ Current every day smoker
- ◯ Current some day smoker
- ◯ Former smoker
- ◯ Never smoker
- ◯ Smoker, current status unknown
- ◯ Light tobacco smoker
- ◯ Heavy tobacco smoker
- ◯ Unknown if ever smoked

Drug Use

- ◯ None

	Type	Quantity	Number	Frequency
◯	Recreational Drug Use			

Occupation:_____

Family Medical History

- ◯ No knowledge of family history

No family history of ◯ Colon Cancer ◯ Colon Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather
Family History of Colon Cancer (what age?)	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Celiac disease	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Colon Polyps	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Colitis	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Crohn's	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Esophageal Cancer (what age?)	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Liver Disease/Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Pancreatitis/Pancreatic Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Stomach Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Breast Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Ovarian Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Uterine Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Lynch Syndrome	◯	◯	◯	◯	◯	◯	◯	◯

Review of systems for symptoms experienced in the last 90 days.

Review Of Systems

Cardiovascular

◯ None	Y	N
chest pain	◯	◯
irregular heart beat	◯	◯
passing out/fainting	◯	◯

Constitutional

◯ None	Y	N
fatigue	◯	◯
loss of appetite	◯	◯
weight loss	◯	◯
fever/chills	◯	◯

Integumentary

◯ None	Y	N
hives	◯	◯
itching	◯	◯
rashes	◯	◯

ENMT

◯ None	Y	N
Eye Pain	◯	◯
frequent nose bleed	◯	◯
mouth sores	◯	◯
hoarseness	◯	◯

Respiratory

◯ None	Y	N
cough	◯	◯
wheezing	◯	◯
shortness of breath	◯	◯

Gastrointestinal

◯ None	Y	N
abdominal pain	◯	◯
abdominal swelling	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
heartburn	◯	◯
trouble swallowing	◯	◯
red blood in stool	◯	◯
vomiting	◯	◯
vomiting of blood	◯	◯
rectal pain	◯	◯
jaundice	◯	◯
nausea	◯	◯
incontinence of stool	◯	◯

Genitourinary

◯ None	Y	N
painful/burning urination	◯	◯
blood in urine	◯	◯
urinary incontinence	◯	◯
prostate trouble	◯	◯
Abnormal Vaginal Bleeding	◯	◯
Change in Periods	◯	◯
Vaginal Discharge	◯	◯

Endocrine

◯ None	Y	N
excessive thirst	◯	◯
hair loss	◯	◯
heat intolerance	◯	◯

Musculoskeletal

◯ None	Y	N
arthritis	◯	◯
back pain	◯	◯
joint pain	◯	◯
muscle weakness	◯	◯

Neurological

◯ None	Y	N
dizziness	◯	◯
frequent headaches	◯	◯
numbness or tingling	◯	◯
seizures	◯	◯
tremors	◯	◯

Hematologic/Lymphatic

◯ None	Y	N
easy bruising	◯	◯
prolonged bleeding	◯	◯
enlarged lymph nodes	◯	◯

Psychiatric

◯ None	Y	N
anxiety	◯	◯
depression	◯	◯
panic attacks	◯	◯

By signing your name, you are agreeing that all the information you have disclosed is accurate.

Signature Date

ADDITIONAL QUESTIONS TO "BYPASS" OFFICE VISIT

For your safety please fill in all Pre-Procedure Screening information below.

1. Have you ever had a colonoscopy before? YES NO
   a. If so, when and where was it done? _____
2. Is this colonoscopy being done for a screening purpose? YES NO
3. What symptom(s) if any, are you having? _____
4. Do you take any medication for upset stomach or reflux? YES NO
   a. If yes, have you ever had an Esophagogastroduodenoscopy (EGD)? YES NO
5. Are you having any problem swallowing food? YES NO
6. Have you ever had any **complications/airway issues to anesthesia**? YES NO
   a. If yes, please specify: _____
   b. Do you have sleep apnea? YES NO If yes, do you use a CPAP? YES NO
7. Do you take any **blood thinners** (Aspirin, Coumadin, Plavix, Warfarin, Xarelto, etc.)? YES NO
   a. If yes, please specify: _____
   b. Who is the prescribing physician? _____
8. Do you take any **prescription or over-the-counter diet pills**? YES NO
   a. If yes, please specify: _____
9. Are you **diabetic**? YES NO
   a. If yes, how is it controlled? _____
   b. **Oral Medications**: Specify name and dose: _____
   c. **Insulin:** Specify name and dose: _____
10. Do you have an **Artificial Heart Valve**? YES NO
    a. If yes, please specify: MITRAL_____ AORTIC_____
    b. Do you have a **Pacemaker**? YES NO If yes, date of placement: _____
11. Do you have a **Defibrillator**? YES NO If yes, date of placement: _____
12. Do you have **Heart Stents**? YES NO
    a. If yes, how many? _____ Date of placement: _____
13. Do you have a personal history of **Cancer**? YES NO
    a. If yes, specify type and treatment: _____
14. Do you have an active **Portacath** (large permanent IV in your chest or arm)? YES NO
    a. If yes, specify last date it was used: _____

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SIGNATURE: _____ Date: ___/___/_____