Hadiatou Barry, MD - Alan Cox, MD
Dylan Gerlach, DO - John Horlander, MD
Michael Krease, DO - Sunana Sohi, MD

Thank you for choosing **Louisville Endoscopy Center!** Our gastroenterologists and staff are dedicated to providing quality, affordable care to the community in our quest to lower colon cancer rates and treat an array of digestive diseases. We are required by the state of Kentucky to collect the information on these forms. Do not leave any information blank and mark the appropriate boxes.

Your procedure will be scheduled after all information is received and processed. This can take up to 4 weeks. 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 meet your needs. Once scheduled you will receive additional paperwork in the mail with appointment date and time. Times are tentative based on the Physician's schedule. Cancellations must be made 48 hours **in advance,** or a cancellation fee of $150 may be applied.

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

Is there a specific physician you prefer: _____

Is there a specific date(s) you prefer: _____

Is there specific date(s) you are unavailable: _____

You will be sedated for your procedure. You must arrange for someone 18 years of age or older to drive you, who will remain on the premises while you are at the Center. The lingering effects of sedation make it unsafe for you to drive, operate machinery, make critical decisions, or do activities that require coordination or balance the day of your procedure. You may resume normal activity the next day. Public/commercial/medical transportation may be used if accompanied by a responsible adult who will be staying with you. The trusted individual escorting you will also be asked to sign medical discharge papers.

At the time of your visit, you will need to bring your insurance card with you. Your insurance coverage is an agreement between you and your insurance company. It is your duty to confirm your medical benefits and coverage with your insurance company prior to your procedure. If your insurance requires a referral, you must request one from the referring physician. Deductibles, co-insurance, and non-covered services are your financial responsibility and will be collected at this time. The Louisville Endoscopy Center does not perform billing services. Those services are provided by Gastroenterology Health Partners and Amsurg. You may receive separate bills for the physician, the anesthesia, the facility, and pathology if specimens are taken during your procedure.

REGISTRATION INSTRUCTIONS

- Complete the enclosed registration forms.
- Copy your insurance card(s) front and back making note of primary and secondary, if applicable.
- If you have had a previous colonoscopy by a physician not affiliated with this facility, please provide us with a copy of the procedure report and pathology, if applicable.
- Mail or Fax completed registration forms and all other paperwork to the Center.
    - Louisville Endoscopy Center Attn: Scheduling 1400 Poplar Level Rd. Louisville, KY. 40217
    - Fax 502-636-4032 Main Number 502-636-2003 Scheduling 502-259-0029

PATIENT DEMOGRAPHIC INFORMATION (please print)

Today's Date: _____/_____/_____

Patient Name: _____

FIRST MI LAST

Date of Birth: _____/_____/_____ **Sex:** ☐ ☐ **SSN:_____-___-_____**

Address: _____

STREET APT# CITY STATE ZIP

Mobile Phone: (_____)_____-_____ **Home Phone: (_____)_____-_____**

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: (_____)_____-_____**

PHARMACY INFORMATION

Local Pharmacy Name, Address, and Phone #:

_____

_____

Mail Order Pharmacy Name, Address, and Phone #:

_____

_____

INSURANCE INFORMATION (complete all information for billing purposes)

Primary: _____

INSURANCE COMPANY CERTIFICATE OR ID# GROUP#

Policy Holder:_____ Relationship: _____

Policy Holder Date of Birth: _____/_____/_____ SSN of Policy Holder: _____-___-_____

Secondary: _____

INSURANCE COMPANY CERTIFICATE OR ID# GROUP#

Policy Holder:_____ Relationship: _____

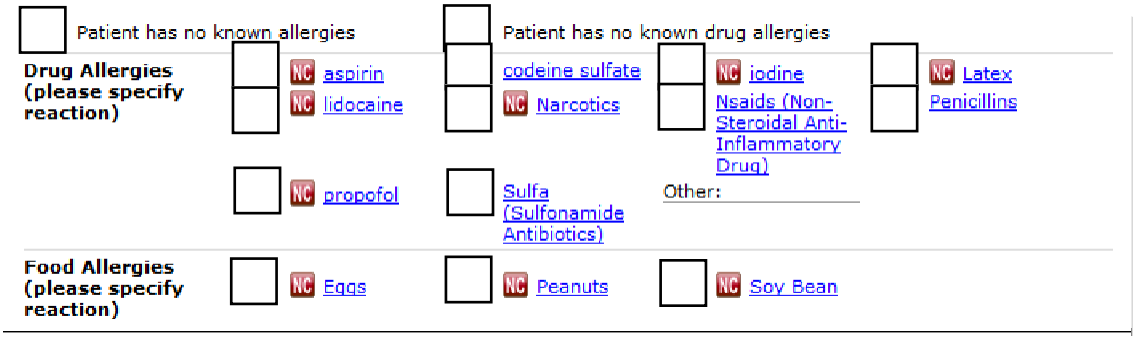
Policy Holder Date of Birth: _____/_____/_____ SSN of Policy Holder: _____-___-_____

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: _____

PATIENT INTERVIEW FORM

Allergies – specify reaction



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

NAME	DOSE	FREQUENCY (once a day, twice a day, etc.)

Immunizations

- [ ] None
- [ ] Flu vaccine
- [ ] Meningococcal
- [ ] Hepatitis A
- [ ] Pneumonia Vaccine
- [ ] Hepatitis B
- [ ] PPD
- [ ] Hepatitis C
- [ ] Shingles
- [ ] HPV
- [ ] 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
- [ ] Crohns Disease
- [ ] Hepatitis Type:_____
- [ ] Stomach Ulcer
- [ ] Colitis
- [ ] Diverticulitis
- [ ] Hiatal Hernia
- [ ] Colon cancer
- [ ] Diverticulosis
- [ ] Irritable Bowel Syndrome
- [ ] Colon polyps
- [ ] GERD/heartburn
- [ ] Pancreatitis

Other:_____

Other Illnesses

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

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	☐	☐

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	☐	☐

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	☐	☐

ADDITIONAL QUESTIONS

1. Have you ever had a colonoscopy before? ☐ YES ☐ NO
   a. If so, when and where? _____
2. Is this colonoscopy being done for a screening purpose?
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

If yes, specify last date it was used: _____

Once signed, please email this PDF to Deanna Lennon, bypass coordinator, at DLennon@amsurg.com.

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

Date: _____/_____/_____ Signature: _____