Gastroenterology Consultants of South Texas

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Welcome to our practice. We appreciate the trust and confidence you have placed in us, and we are committed to providing you with the best health care services. In order to serve you properly, we will need the following information (please print). All information will be held strictly confidential.

Patient Information

Last Name:__________________ First Name:____________________ Middle Initial:__________

Mailing Address:_______________________________ City/State:_______________ Zip Code: ___________

Home Phone: _______________ Cell Phone:_________________ Work Phone: _______________ Ext._____

Date of Birth: __________________ ☐ Male ☐ Female Social Security #:______________________

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed Email Address: ________________________

Employer Name: _________________________ Primary Care Doctor: ____________________________

Preferred Pharmacy

Pharmacy Name:______________________ City: ________________________ Phone: __________________

Emergency Contact Information

Last Name__________________ First Name __________________ Relationship to Patient______________

Home Phone: _______________ Cell Phone: __________________ Work Phone: _____________________

Social History

1. Have any family members had Colon or Stomach Cancer? ☐ No ☐If yes, specify relation to you:

Colon Cancer: ____ _____________________ Stomach Cancer: ________________________

2. How many biological children do you have? Sons: ________ _ Daughters: ___________

Please note if you have ever had any of the following:

3. Colonoscopy? ☐No ☐ Yes, year _______

4. Upper Endoscopy? ☐No ☐Yes, year? ________

5. Blood Transfusion? ☐No ☐Yes, year? __________

6. Tattoos: ☐No ☐Yes

7. Caffeine? (Coffee, Soda, Tea) ☐Never ☐Daily: #______ cups/day ☐ Occasionally

8. Recreational Drug Use: ☐ Never ☐ Quit Using ☐ Currently Using

9. Alcohol? ☐ Never ☐ Daily ☐ Occasional ☐ Quit Drinking, year _______

10. Tobacco Smoking? ☐ Never ☐ Daily ☐ Occasional ☐ Quit Smoking, year ______

Medical History (Please check if it applies)

☐ High Blood Pressure	☐ Anxiety/Depression	☐ Hepatitis C
☐ High Cholesterol	☐ Asthma	☐ HIV
☐ Heart Murmur	☐ Hypothyroidism	☐ Arthritis
☐ Heart Failure	☐ Diabetes Type II	☐ Seizures
☐ COPD/ Emphysema	☐ Anemia	☐ Kidney Stones
☐ Deep Venous Clots	☐ Kidney Disease	☐ TB/Positive PPD
☐ Heart Artery Disease	☐ Osteoporosis	☐ Cancer: (please specify)
☐ Hemorrhoids	☐ Heart Attack, date(s)	________________________
☐ Stroke, date(s):________	________________	Other________________________

Review of Systems

		Yes	No		Yes	No
Hematological	Bleeding or Bruising			Anemia		
Gastroenterology	Difficulty Swallowing			Abdominal Pain		
General	Fever/Night sweats			Fatigue/Weakness		
Dermatology	Rash			Itching		
Endocrinology	Excessive Thirst			Hair Loss		
Neurology	Headaches			Lightheaded/Dizziness		
Ophthalmology	Blurred Vision			Drainage from Eyes		
EENT	Ringing in ears			Chronic Cough		
Cardiology	Palpitations			Shortness of Breath		
Musculoskeletal	Joint Pain			Leg Cramps		
Psychiatric	Memory Loss/Confusion			Anxiety		

Previous Surgeries/Episodes (Please check if it applies)

Procedure	Date(s)	Procedure	Date(s)
☐ Gall Bladder Removal		☐ Appendix removal	
☐ Gastric Bypass		☐ Hernia repair	
☐ Heart Bypass surgery		☐ Heart stent	
☐ Heart Pacemaker		☐ Tonsillectomy	
☐ Artificial heart valve		☐ Knee Replacement	
☐ Hip Replacement: Left Right		☐ Mastectomy: Left Right	
☐ Hysterectomy: Partial Complete		☐ Cataract: Left Right	
☐ C-Section		Other:	

Medications Information

Please list all medications currently taking (Name only), including over-the-counter and vitamins

____________________ ____________________ ____________________ ______________________

____________________ ____________________ ____________________ ______________________

____________________ ____________________ ____________________ ______________________

Drug Allergies? ☐No ☐Yes, Please list: ____

Gastroenterology Consultants of South Texas
Notice of Privacy Practice Act

Gastroenterology Consultants of South Texas, PA does not disclose medical information with anyone other than the patient without written consent unless required by law or insurance purposes. Complete privacy practices are available upon request. Patients using insurance agree to assign medical benefits which are entitled to Gastroenterology Consultants of South Texas, PA.

For any questions, more information, or to report a problem with the way we have handled your protected health information please contact Sandy Perez at 512 Victoria Lane, Suite 2, Harlingen TX 78550 or call 956-365-4400.

Please sign to indicate your receipt of our policy.

______________________________ ______________________

Signature of patient or legal guardian Date

Other disclosures and uses of protected health information:

Notification of family and others: We do not release information to family members or other caretakers about your medical care or financial information. Written authorization is needed if you wish for us to disclose your healthcare with others. Please list the information of whom you wish to allow information to be given.

1. ______________________ ______________________

Name Relationship

______________________ ______________________

Phone Number Address

2. ______________________ ______________________

Name Relationship

______________________ ______________________

Phone Number Address

Disclosure:

Our Providers have vested interest in Gastroenterology Consultants of South Texas, Platinum Surgery Center, Value Pathology Associates, and the anesthesia service providers at the ambulatory surgery centers.