VALDOSTA
Gastroenterology Associates
and
Endoscopy Center

PATIENT DATA

FORM MUST BE COMPLETED IN FULL

Name _____ Today's Date _____

Social Security # _____ Date of Birth _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Gender ☐ Male ☐ Female

Home Address _____
Street City State Zip

Phone Numbers: Home _____ Cell _____ Work _____

Primary Phone is: ☐ Home ☐ Cell ☐ Work Reminder Call Made to: ☐ Home ☐ Cell ☐ Work

Email Address: _____ Preferred Contact Method: ☐ Phone ☐ Mail ☐ Email

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Other_____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

EMPLOYMENT

Employer _____ Dept. / Title _____

Employer's Address _____
Street City State Zip

Referred by _____
Name Phone

Address _____
Street City State Zip

EMERGENCY CONTACT

Spouse, companion, relative or friend living with you

Name & Relationship _____ Daytime phone _____

Nearest relative or friend not living with you

Name & Relationship _____ Daytime phone _____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent to be treated by the staff and providers of Valdosta Gastroenterology Associates and Valdosta Endoscopy Center, LLC (also referred to on these forms as VGA/VEC). I authorize payment of medical benefits to VGA/VEC, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non covered services.

Patient / Guarantor Signature * _____ Date _____

* If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

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NEW PATIENT
PERSONAL HISTORY

Today's Date _____

1) Name _____ Age _____ Date of Birth _____

2) Referred by _____ Primary Care Physician _____

3) Other physicians involved in your healthcare _____

4) Describe the reason(s) for you visit _____

_____

5) List ALL recent medical problems, illnesses (including cancers), hospitalizations and surgeries.

_____ _____

_____ _____

_____ _____

6) List the most recent date any of the following tests or procedures were performed.

Labs_____ X-rays_____ CT Scan of Abdomen_____

Barium Enema _____ Ultrasound_____ Upper Endoscopy _____

Colonoscopy _____ Hemorrhoidectomy_____ Banding_____

Sclerotherapy _____ IRC (Infared Coagulation) _____

7) Are you currently taking blood thinners (Coumadin, Plavix, Warfarin, Pradaxa)? Please Circle ☐ Yes ☐ No

Are you currently taking aspirin/NSAIDs? ☐ Yes ☐ No
(Ibuprofen, Advil, BC Powder, Goody's Powder, Naprosyn, Aleve)? Please Circle

8) SOCIAL HISTORY

Provide details regarding current and/or past use of the following.

Alcohol (beer, wine, liquor) ☐ Yes ☐ No Usage: ☐Daily ☐Occasional ☐Rarely ☐Former

I.V. or Recreational Drugs ☐ Yes ☐ No Usage: ☐Daily ☐Occasional ☐Rarely ☐ Former

Tobacco (cigarettes, cigars, chewing tobacco) ☐ Yes ☐ No Usage: ☐Daily ☐Occasional ☐Rarely ☐Former

9) FAMILY HISTORY (BLOOD RELATIVE)

Colon Cancer ☐ Yes ☐ No Relation _____ Age of Diagnosis _____

Colon Polyps ☐ Yes ☐ No Relation _____ Age of Diagnosis _____

Crohn's Disease/Colitis ☐ Yes ☐ No Relation _____

Liver Disease ☐ Yes ☐ No Relation _____ Type of disease _____

List any other hereditary or significant conditions experienced by a blood relative, such as gall bladder disease, heart disease, hypertension, diabetes, etc. _____

11) **SYSTEMS REVIEW:** Do you have or have you recently experienced any of the following?

DIGESTIVE SYSTEM	Yes	No
Difficulty in Swallowing	☐	☐
Heartburn/Esophageal Reflux	☐	☐
Nausea/Vomiting	☐	☐
Indigestion	☐	☐
Bloating/Belching/Gaseousness	☐	☐
Abdominal Pain	☐	☐
Gallstones/Gallbladder Disease	☐	☐
Hepatitis or Liver Disease	☐	☐
Crohn's Disease/Ulcerative Colitis	☐	☐
Irritable Bowel Syndrome	☐	☐
Gastrointestinal Bleeding	☐	☐
Hemorrhoids	☐	☐
Constipation	☐	☐
Diarrhea/Loose Stools	☐	☐
Change of Bowel Habits	☐	☐
Rectal Bleeding (in stool, commode, toilet paper)	☐	☐
Black Stool	☐	☐
Mucus in Stool	☐	☐
Unintentional Weight Loss (amount)	☐	☐
Anal/Rectal Pain or Itching	☐	☐
Anal Spasm	☐	☐
Anal Fissures	☐	☐

ALLERGY/IMMUNOLOGY		
HIV/AIDS	☐	☐
Blood Transfusion	☐	☐

CARDIOLOGY		
Chest Pain	☐	☐
Pacemaker	☐	☐
History of Heart Attack	☐	☐
Mitral Valve Prolapse or Murmur	☐	☐
Artificial Heart Valve	☐	☐
Hypertension	☐	☐
Defibrillator	☐	☐

EARS, EYES, NOSE, MOUTH, THROAT		
Hearing Loss	☐	☐
Ear Pain/Ringing	☐	☐
Mouth Ulcers/Sores	☐	☐
Poor Dentition	☐	☐
Nose Bleeds	☐	☐
Visual Changes	☐	☐

ENDOCRINE	Yes	No
Diabetes	☐	☐
Thyroid Problem	☐	☐
Hormonal Problem	☐	☐
High Cholesterol	☐	☐

GENITOURINARY		
Are you pregnant?	☐	☐
Date of last period? _____		
Recent/Frequent Urinary Tract Infection	☐	☐
Blood in Urine	☐	☐
Burning with Urination	☐	☐
History of Kidney Stones	☐	☐

LYMPHATIC/HEMATOLOGY		
Enlarged Nodes/Swollen Glands	☐	☐
Anemia	☐	☐
Bleeding Problems	☐	☐

MUSCULOSKELETAL SYSTEM		
Lupus, Scleroderma, Related Diseases	☐	☐
Joint Pain/Arthritis	☐	☐
Back Pain	☐	☐
Problems Walking	☐	☐

NEUROLOGY		
Seizure Disorder	☐	☐
Headaches	☐	☐
Stroke	☐	☐

PSYCHIATRY		
Depression/Anxiety	☐	☐
Past Evaluation/Treatment	☐	☐

PULMONARY		
Shortness of Breath	☐	☐
Asthma/Wheezing/Cough	☐	☐

SKIN		
Dermatitis	☐	☐
Itching	☐	☐
Psoriasis	☐	☐
Jaundice (yellow eyes or skin)	☐	☐

OTHER _____

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MEDICATION LIST

Patient Name	
Name of Pharmacy	Patient's Date of Birth
Pharmacy Location	Last 4 digits of SS#

Name of Medication	**Dose (How much taken)**	**Frequency (How often do you take?)**	
LIST ALLERGIES HERE			
Name of medication you are allergic to:	**Type of reaction you experienced (if known)**		

This form may be faxed to (229) 247-1084 or brought with you on your next office visit.