Swan Gastro & Surgery Center

1505 N. Swan Rd, Tucson AZ 85712 (520) 795-3090 Fax (520) 798-3537 www.stomachdoc.com www.swangastro.com

Patient Information

Patient Name (Last) _____ (First) _____ (Middle) _____

Sex □ Male □ Female □ Trans Gender Date of Birth_____/_____/_____ SS#:_____-_____-_____

Email: _____ Mailing Address_____

Home Address (Street) _____ (City/State&/Zip) _____

Home Phone: _____ Cell Phone: _____ Work: _____

Emergency Contact: _____ Phone #_____ Relationship: _____

Marital Status: □ Married □ Single □ Divorced □ Widow **Ethnicity**: □ Hispanic □ Non-Hispanic
Race: □ White □ Black or African American □ American Indian □ Alaska Native □ Native Hawaiian or Other Pacific Islander □ Other Race □ Refused to Report

Employment Status:

Employer: _____ Address: _____

Occupation: _____ Work Status: □ Full time □ Part time □ Unemployed □ Student

Primary Care Physician: _____Phone: _____

Pharmacy Name_____Location:_____Phone:_____

Insurance Information: (Please Provide Your Insurance Card for Us to Scan)

1. Primary insurance Company_____

Policy Holder Name: _____ D.O.B:_____ Relationship: □ Self □ Spouse □ Dependent

Employer of Policy Holder_____ ID#_____ Group #_____

2. Secondary insurance Company_____

Policy Holder Name: _____ D.O.B:_____ Relationship: □ Self □ Spouse □ Dependent

Employer of Policy Holder_____ ID#_____ Group #_____

If you do not have medical insurance, you will be responsible for full payment for the service. A minimum deposit of $150.00 is required prior to the service. This, in most cases, is not the full amount. Please feel free to discuss this further with the billing office. All chargers including co-pays and deductibles are due at the time of service

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Name: _____ **DOB:** _____

Review of System

General/Constitutional	☐ Fatigue	☐ Fever	☐ Weight loss
Ophthalmologic	☐ Yellow Eye	☐ Pain	
ENT	☐ Hoarseness of voice	☐ Sore Throat	
Respiratory	☐ Cough	☐ Wheezing	
Cardiovascular	☐ Chest pain at rest	☐ Palpitations	

Gastrointestinal

☐Abdominal Pain	☐ Blood in Stool	☐ Change in bowel habits
☐ Constipation	☐ Decrease Appetite	☐ Diarrhea
☐ Difficulty Swallowing	☐Exposure To Hepatitis	☐ Heartburn
☐ Hematemesis	☐Nausea	☐Vomiting
☐ Rectal bleeding	☐ Weight loss	

Hematology	☐ Anemia	☐ Dizziness	
Skin	☐ Body piercing	☐ Rash	
Neurologic	☐		
Seizures			
Psychiatric	☐ Depressed mood	☐ Substance Abuse	☐ Suicidal thoughts
Health Education	☐Hepatitis "A" Vaccination	☐Hepatitis "B" Vaccination	
	☐ Smoking cessation	☐ Flu Shot	

CURRENT MEDICATIONS: (List all medications, including oral contraceptives, over the counter medications, Herbal medications, and health supplements)

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Have you been prescribed narcotic medications in the past 1-year ☐ Yes ☐No

ALLERGIES: ☐ No ☐ Yes (if yes list allergies below and type of reaction)

_____
_____
_____

☐Shell fish/seafood allergy ☐Allergy to dye in CT scan and other imaging studies

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Patient Name _____ **Male** **Female** Date _____

Age _____ Birth Date _____ Referred by_____

➡ What is the primary medical problem for which you seek evaluation, information, or treatments?

_____

PAST HISTORY:

➡ Please indicate if you have or have had any of the following diseases:

Acid Reflux	Ulcers	Hemorrhoids	Hepatitis
Jaundice	Heart murmur	Heart Attack	Pacemaker/ AICD
Stroke	Suicide attempts	Anemia	Tuberculosis
Herpes	Shingles	Mononucleosis	Schizophrenia
Anxiety	Panic attacks	Depression	Obsessive compulsive disorder
Bipolar disorder	Recent 'flu-type' illness		Cancer, Type _____
			_____
			_____

➡ **List All Other Chronic Medical Conditions**: (e.g. - high blood pressure, diabetes, heart disease, irregular heart rhythm, blood clots, COPD/emphysema, etc.)

_____ _____

_____ _____

_____ _____

SURGICAL HISTORY:

➡ Have you had any surgery? **(Type of operation and approximate date)**

_____ _____ _____

_____ _____ _____

➡ In the past 5 years have you had any of the following? Please check the appropriate answer.

1. Stool tested for blood	No	Yes	Date _____
2. Colonoscopy or Flexible Sigmoidoscopy	No	Yes	Date _____
3. CAT scan of abdomen	No	Yes	Date _____
4. Barium enema or Barium upper gastrointestinal series	No	Yes	Date _____
5. Liver biopsy	No	Yes	Date _____
6. EGD or Upper Endoscopy	No	Yes	Date _____

➡

Patient Name: _____ *Date:* _____

Family History: Do you know of any relative who has or had any of the following cancers or diseases?

Cancer History: Please specify who in your Family has or had the following Cancer

Esophageal _____
Stomach _____
Colon _____
Liver _____
Pancreas _____
Other _____
_____
_____

Diseases in the Family: Please specify who in your Family has or had the following Diseases

Ulcerative Colitis	Hepatitis B or C	Stroke/ Transient stroke
Crohn's Disease	Epilepsy	Migraine
Colon Polyps	Acid Reflux	Lung Disease
Irritable Bowel Syndrome	Liver Disease	Mental Illness
Celiac disease	Heart Disease	Alcohol/Drug Abuse
High Cholesterol	Diabetes	Ulcers
Kidney Disease	Genetic Disorders	Arthritis

Social History

Substance	Current Use	Previous Use	Type / Amount	How long / Frequency	If Stopped, when?
Caffeine (coffee, tea, soda)					
Tobacco					
Alcohol					
Recreational or Street drugs					

PERSONAL HISTORY:

1. Education: How many years of school have you completed?_____

2. Disability: Are you disabled? No Yes Cause:_____

3. Current Spouse: N/A Alive Health problems or cause of Death _____

If alive, current employment status: Homemaker Employed Retired Unemployed

Current Occupation of spouse: _____

4. Number of Children _____ Boys _____ Girls _____

5. Have you ever been Physically, Sexually, or emotionally abused? No Yes