Gastro-Intestinal Consultants of Manhattan, P.A.

W. Travis Dierenfeldt, M.D. **Robert J. Starnes, P.A.- C**

Gastroenterology Consultation

Welcome to Gastro-Intestinal Consultants of Manhattan, P.A. Your doctor has recommended that you see a gastroenterologist for a gastro-intestinal consultation.

You will find the following items enclosed:

- Patient Registration Form
- Medical History Form
- Patient Information Brochure

Please complete the enclosed forms prior to your appointment. If you have any questions please call our office at 785-539-0156 or Toll Free 1-866-766-1166.

Your appointment is scheduled for _____@ _____. Please arrive 15-20 minutes early with the enclosed paperwork completed.

Thank You

1213 Hylton Heights Road • Suite 101 • Manhattan, Kansas 66502
785-539-0156 • Toll Free 1-866-766-1166 • FAX 785-539-0177

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Medical History Form

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Date / /
Name_____ Date of Birth _____ Age_____

Primary care physician's name_____ Pharmacy and location _____

What is the main reason for your visit today? _____

Medical History (check all that apply)
Have you had or been diagnosed with any of the following gastro-intestinal conditions?

☐ Esophageal Reflux	☐ Hiatal hernia	☐ Chronic Diarrhea	☐ Fatty Liver
☐ Barrett's Esophagus	☐ Colon Polyps	☐ Chronic Constipation	☐ Autoimmune Hep
☐ Esophageal Stricture (narrowing)	☐ Colon Cancer	☐ Gallstones	☐ PBC
☐ Esophageal Varices	☐ Crohn's Disease	☐ Pancreatitis	☐ PSC
☐ Gastritis	☐ Ulcerative Colitis	☐ Pancreatic Cancer	☐ Cirrhosis of Liver
☐ Helicobacter Pylori Infection	☐ Irritable Bowel Syndrome		☐ Hepatitis A
☐ Stomach Ulcer	☐ Diverticulosis		☐ Hepatitis B
☐ Duodenal Ulcer	☐ Diverticulitis		☐ Hepatitis C

Have you had or been diagnosed with any of the following other conditions?

☐ High blood pressure	☐ Anemia, iron deficiency	☐ Emphysema	☐ Blood Transfusion
☐Heart Murmur	☐ Anemia, blood loss	☐ Asthma	☐Other _____
☐Heart Disease	☐ Anemia, unspecified	☐ Breast Cancer	☐Other _____
☐High Cholesterol	☐ Diabetes	☐ Uterine Cancer	☐ Other _____
☐ Artificial Heart Valve	☐ Thyroid disorder	☐ Prostate Cancer	
Please list any other medical problems you have had in the past.		☐ Radiation Treatment	

Surgery History (check all that apply)

	Year		Year		Year
☐ Gallbladder Removal		☐ Tonsillectomy		☐ Joint Replacement	
☐ Appendix Removal		☐ Tubal Ligation		☐ Mastectomy	
☐ Gastric bypass		☐ Hysterectomy		☐ Upper endoscopy	
☐ Colon Resection		☐ Heart Bypass		☐ Colonoscopy	
☐ Hernia Repair		☐ Vascular Surgery		☐ Other	
☐ Nissen Fundoplication					

Current Medications (medications you are taking or have taken in the last 2 months)

Do you take: ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Ibuprofen ☐ Naproxen/Aleve ☐ Other NSAID

If yes, how often? _____

Name of Medication	Dose	Name of Medication	Dose

Are you allergic to any medications? ☐ YES ☐ No If YES, list medications and type of reaction you had?

Name of Medication	Reaction	Name of Medication	Reaction

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Family History ☐ Adopted

List diseases of your Mother, Father, Sister, or Brother Mother=M Father=F Sister=S Brother=B

	M	F	S	B		M	F	S	B		M	F	S	B
☐ Colon Polyps					☐ Crohn's Disease					☐ Gallbladder disease				
☐ Colon Cancer					☐ Pancreatitis					☐ Stomach Ulcer				
☐ Irritable Bowel Syndrome					☐ Liver Disease					☐ Duodenal Ulcer				
☐ Ulcerative Colitis					☐ Hepatitis					☐ Other GI Diseases				

Social History

What is your occupation? _____

Do you drink alcohol?	☐ Currently	☐ In Past	☐ Never
Do you Smoke?	☐ Currently	☐ In Past	☐ Never
Have you ever used intravenous drugs?	☐ Currently	☐ In Past	☐ Never

Review of Systems (check all that apply)

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weakness
- ☐ Fatigue

Ears,Eyes,Nose,Throat
- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Nasal congestion
- ☐ Sore throat

Respiratory
- ☐ Short of breath
- ☐ Cough
- ☐ Sputum production
- ☐ Blood in sputum
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Slow heart
- ☐ Fast heart
- ☐ Edema
- ☐ Passing out

Gastrointestinal
- ☐ Nausea
- ☐ Vomitting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Blood in vomit
- ☐ Abdominal pain

Urinary
- ☐ Painful urination
- ☐ Blood in urine

Heme/Lymph
- ☐ Bruise easily
- ☐ Bleed easily
- ☐ Swollen lymph glands

Endocrine
- ☐ Excessive thirst
- ☐ Frequent urination
- ☐ Cold intolerance
- ☐ Heat intolerance

Musculoskeletal
- ☐ Back pain
- ☐ Neck pain
- ☐ Joint pain
- ☐ Muscle pain

Skin
- ☐ Rash
- ☐ Itching
- ☐ Abrasions

Neurologic
- ☐ Confusion
- ☐ Numbness
- ☐ Tingling
- ☐ Headache

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Mania
- ☐ Delusional
- ☐ Hallucinations

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Patient Registration Form

*****Personal Information*****

Last Name	First Name		Middle Name
Home Address	City	State	Zip Code
Phone ☐Home ☐Cell	Date of Birth	Social Security Number	
Your Occupation	Email		
Employer		Business Phone	
Employer Address	City	State	Zip Code
Marital Status ☐Married ☐Single ☐ Widowed ☐Divorced ☐ Separated			
Gender ☐Male ☐ Female	Race/Ethnicity	Preferred Language	

*****Contact Information*****

Name of Spouse or Nearest Relative			Relationship
Address	City	State	Zip Code
Home Telephone		Social Security Number	
Employer		Business Phone	

*****Physician Information*****

Referring Physician
Primary Care Physician

*****Responsible Party if other than Patient*****

Last Name	First Name		Middle Name
Address	City	State	Zip Code
Telephone			
Employer		Business Phone	
Employer Address	City	State	Zip Code

*****Insurance Information*****

Insurance Company Name	Identification Number	Subscriber's Name
Primary Insurance Name	Identification # Group Name and #	Subscriber's Name Date of Birth
	Your relationship to subscriber ☐Self ☐Spouse ☐Child ☐ Other	
Secondary Insurance Name	Identification # Group Name and #	Subscriber's Name Date of Birth
	Your relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐Other	

*****Authorization to Release Information and Assignment of Insurance Benefits*****

I hereby authorize this medical practice to release to my insurance company(s) all information that said party(s) may request concerning my illness or injury. I hereby assign to this medical practice all monies to which I am entitled for the medical expenses relative to the services reported but not to exceed my indebtedness to this medical practice. I understand I am financially responsible to this medical practice for all charges personally incurred here and agree to be personally and fully responsible for payment of this account. I also authorize the exchange of medical records and/or information concerning my condition with other physicians, allied health providers, or medical facilities as determined by the clinical staff of this medical practice to be in the best interest of my medical treatment. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Signature	Today's Date
Signature of Responsible Party	☐ Parent ☐ Guardian

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