719 North Cascade Ave
Colorado Springs, CO 80903
(719) 433-7224

2920 North Cascade Ave, Ste 300
Colorado Springs, CO 80907
Main Ph (719) 636-1201
&
1370 Interquest Pkwy, Ste 320
Colorado Springs, CO 80921

2920 North Cascade Ave, 1st Floor
Colorado Springs, CO 80907
(719) 362-2300

PATIENT DEMOGRAPHICS

Legal Name:____ DOB: _________________ Age: _______

Address: ____ SSN: _____-_____-_____

City: ____________________ State: _____ Zip:________ Email:____

Phone: (H)__________________ (C)__________________ Sex: □ Male □Female

Marital Status: __________Ethnicity/Race:______________ Primary Doctor: ____________________________

Employer:____ Referring Doctor: ___________________________

Preferred Language(s): ____

EMERGENCY CONTACT

Name: ______________________________ Relationship: __________________Phone: _________________________

INSURANCE INFORMATION

Primary Insurance: ____________________________________ ID #: _______________

Policy Holder, if not patient: __________________________ DOB: _______________ SSN: _____-_____-_____

Secondary Insurance: _______________________________ID #: ________________

Policy Holder, if not patient: __________________________ DOB: _______________ SSN: _____-_____-_____

If patient is under 18 years old, please fill out information regarding parent/guardian accompanying minor child

Name: ____________________________Relationship: ____________ DOB:__________ SSN:______-______-_____

Address: ________________________________ City:_______________________ State:________ Zip: ____________

Is your insurance part of the Affordable Care Act (Obama-Care)? ☐ ***Yes***

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PHONE MESSAGE CONSENT

I give **Peak Gastroenterology Associates, PC (PGA), Front Range Endoscopy Centers, LLC (FREC), and Surgical Center of Peak Endoscopy, LLC (SCOPE**) permission to leave a phone message regarding my medical care with the following: medical care information including labs, imaging, endoscopy, and other test results as well as appointment times. If I wish to withdraw the consent, I must provide written notice to PGA/FREC/SCOPE stating the date of the requested withdrawal.

My home voicemail: ______________________________

My office voicemail: ______________________________

My cell voicemail: ______________________________

My spouse or other family names and numbers I give permission to leave messages with and/or discuss my medical history:

Name/Relationship: ____________________/________________ **Phone:** ___________________

Name/Relationship: ____________________/________________ **Phone:** ___________________

Name/Relationship: ____________________/________________ **Phone:** ___________________

PATIENT'S LEGAL NAME: ____

Signature: ____

If legally authorized representative, then relationship to patient: ____________________________

Date: ______________________________

PRIOR PROCEDURES

EGD Results:____ Date: __________________

PRIOR PROCEDURES

Colonoscopy Results:____Date: __________________

Sigmoidoscopy Results: ____ Date: __________________

Capsule Endoscopy Results: ____ Date: __________________

PAST MEDICAL HISTORY: *Please write in ALL medical problems you have*

1)	2)	3)	4)
5)	6)	7)	8)
9)	10)	11)	12)

PAST SURGICAL HISTORY: *Please write in ALL surgeries you have undergone.*

1)	2)	3)	4)
5)	6)	7)	8)
9)	10)	11)	12)

FAMILY HISTORY: *Please check the box below for "yes"*

Do family members have a history of:

☐ Celiac Disease	☐ Colon Cancer	☐ Cirrhosis	☐ Pancreatitis
☐ Pancreatic Cancer	☐ Crohn's Disease	☐ Ulcerative Colitis	☐ Stomach Cancer
☐	☐	☐	☐

SOCIAL HISTORY:

Smoking: YES or NO Packs per day: _____________# of Years:_________ Quit Date: ________________

Alcohol: YES or NO Beverage and # per day/week:____________________ Quit Date: ________________

Illicit Drugs: YES or NO Drugs Used:___________________________________ Quit Date: ________________

Tattoos: YES or NO Exercise: YES or NO

Marijuana: YES or NO Amount per day/week:___________________________

HX OF/OR CURRENT INFECTIOUS DIAGNOSIS: ☐MRSA ☐VRE ☐C-Diff

OTHER PERTINENT INFORMATION

____

____

Pharmacy/Location: ____ Phone: ______________________

MEDICATIONS

Please list ALL medications you are taking to include over-the-counter medications and herbal supplements. Please do not write "see attached list."

Prescription Medications

				For Office Use Only	
Name of Medication	Dose	Frequency	Reason for Medication	Continue	Discontinue

Over The Counter Medications or Herbal Supplements

				For Office Use Only	
Name of Medication	Dose	Frequency	Reason for Medication	Continue	Discontinue

ALLERGIES: Please list all your medication allergies

FOR FREC/SCOPE OFFICE USE ONLY

- ☐ Resume all pre-procedure medications
- ☐ New medications and instructions
- ☐ Patient received copy

Name of Medication	Dose	Frequency	Reason for Medication

Ride: ______________________________

Nurse: ______________________________

Physician: ______________________________

Date/Time: ______________________________

Patient Label Here

REVIEW OF SYSTEMS FOR MALES: Please circle if you are experiencing any of these

CONSTITUTION	**EYES**	**GENITOURINARY**	**NEUROLOGICAL**
Activity Change	Eye Discharge	Difficulty Urinating	Dizziness
Appetite Change	Eye Itching	Pain with Urination	Facial Asymmetry
Chills	Eye Pain	Involuntary Urination	Headaches
Sweats	Eye Redness	Flank Pain	Lightheadedness
Fatigue	Light Sensitivity	Frequent Urination	Numbness
Fever	Vision Changes	Genital Sore	Seizures
Weight Change	**RESPIRATORY**	Blood in Urine	Speech Difficulty
HEENT	Sleep Apnea	Penile Discharge	Passing Out/Syncope
Facial Swelling	Chest Tightness	Penile Pain	Tremors
Neck Pain	Choking	Penile Swelling	Weakness
Neck Stiffness	Cough	Scrotal Swelling	**HEMATOLOGIC**
Ear Discharge	Shortness of Breath	Testicular Pain	Large Lymph Nodes
Hearing Loss	Stridor	Urine Urgency	Easy Bruising/Bleeding
Ear Pain	Wheezing	Decreased Urine	**PSYCHIATRIC**
Ringing In Ear	**CARDIOVASCULAR**	**MUSCULOSKELETAL**	Agitation
Nosebleeds	Chest Pain	Joint Pain	Behavior Problems
Nasal Congestion	Leg Swelling	Back Pain	Confusion
Runny Nose	Palpitations	Gait Problem	Poor Concentration
Postnasal Drip	**GI**	Joint Swelling	Sadness
Sneezing	Abdominal Bloating	Muscle Pain	Hallucinations
Sinus Pressure	Abdominal Pain	**SKIN**	Hyperactive
Dental Problem	Anal Bleeding	Color Change	Nervousness/Anxious
Drooling	Blood in Stool	Pallor	Self-Injury
Mouth Sores	Constipation	Rash	Disturbed Sleep
Sore Throat	Diarrhea	Wounds	Suicidal Thoughts
Trouble Swallowing	Nausea		
Voice Change	Rectal Pain		
	Vomiting		
	Fecal Incontinence		

THANK YOU FOR CHOOSING *PEAK GASTROENTEROLOGY ASSOCIATES!*

REVIEW OF SYSTEMS FOR FEMALES: Please circle if you are experiencing any of these:

CONSTITUTION	**EYES**	**GENITOURINARY**	**NEUROLOGICAL**
Activity Change	Eye Discharge	Difficulty Urinating	Dizziness
Appetite Change	Eye Itching	Pain During Sex	Facial Asymmetry
Chills	Eye Pain	Pain with Urination	Headaches
Sweats	Eye Redness	Involuntary Urination	Lightheadedness
Fatigue	Light Sensitivity	Flank Pain	Numbness
Fever	Vision Changes	Frequent Urination	Seizures
Weight Change	**RESPIRATORY**	Genital Sores	Speech Difficulty
HEENT	Sleep Apnea	Blood in Urine	Passing Out/Syncope
Facial Swelling	Chest Tightness	Menstrual Problem	Tremors
Neck Pain	Choking	Pelvic Pain	Weakness
Neck Stiffness	Cough	Urinary Urgency	**HEMATOLOGIC**
Ear Discharge	Shortness of Breath	Decrease Urine	Large Lymph Nodes
Hearing Loss	Stridor	Vaginal Bleeding	Easy Bruising/Bleeding
Ear Pain	Wheezing	Vaginal Discharge	**PSYCHIATRIC**
Ringing In Ear	**CARDIOVASCULAR**	Vaginal Pain	Agitation
Nosebleeds	Chest Pain	**MUSCULOSKELETAL**	Behavior Problems
Nasal Congestion	Leg Swelling	Joint Pain	Confusion
Runny Nose	Palpitations	Back Pain	Poor Concentration
Postnasal Drip	**GI**	Gait Problem	Sadness
Sneezing	Abdominal Bloating	Joint Swelling	Hallucinations
Sinus Pressure	Abdominal Pain	Muscle Pain	Hyperactive
Dental Problem	Anal Bleeding	**SKIN**	Nervousness/Anxious
Drooling	Blood in Stool	Color Change	Self-Injury
Mouth Sores	Constipation	Pallor	Disturbed Sleep
Sore Throat	Diarrhea	Rash	Suicidal Thoughts
Trouble Swallowing	Nausea	Wounds	
Voice Change	Rectal Pain		
	Vomiting		
	Fecal Incontinence		

THANK YOU FOR CHOOSING *PEAK GASTROENTEROLOGY ASSOCIATES!*