DATE COMPLETED:______________________ E __________________________

INDIANA COLON AND RECTAL SPECIALISTS
FRANCISCAN PHYSICIAN NETWORK
Specialists in colon and rectal surgery

☐ **Olaf B. Johansen, M.D.** ☐ **Barry Melbert, M.D.** ☐ **Frederick R. Lane, M.D.**

☐ **Dipen C. Maun, M.D.** ☐ **Ben Tsai, M.D.** ☐ **Tobi Reidy, D.O.**

PATIENT DEMOGRAPHICS

NAME- FIRST:____M.I.:_____________LAST:____

ADDRESS: ____CITY:________________________________ST:__________ZIP:__________

HOME PHONE: ( )______________________________________ CELL PHONE: ( )____

SS#:____EMAIL: ____

BIRTHDATE: ____ AGE: _________ ☐ MALE ☐ FEMALE

Mark here if: ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student

EMPLOYER: ____ ADDRESS: ____

OCCUPATION: ___________________________________ WORK PHONE:________________ ext: _________ ☐ Full time ☐ Part Time ☐ Nights/Evening

MARITAL STATUS: _____________ SPOUSE'S NAME:____________________________________ DOB:_____________ SS#____________________

(Optional to complete: RELIGION: _________________________ RACE: ____________________ ETHNICITY: ☐ Hispanic ☐ Non-Hispanic)

GUARANTOR: ☐ SELF OTHER: ____Relationship to Patient: ____________________________

ADDRESS: ____PHONE: ( )___________________________________

EMERGENCY CONTACT INFORMATION

NAME: ____RELATIONSHIP TO PATIENT: __________________PHONE: ________________

INSURANCE COMPANIES (#1 being primary to file claim to, #2 Secondary etc…) a COPY OF YOUR CARD (S) IS REQUIRED:

COMPANY NAME POLICY HOLDER

1.____________________________________ ☐ SELF or ____ Relationship to patient: _______________

ID # ___________________________ GRP: ______________ DOB: ______________ EMPLOYER:__________________ SS#: _______________

2.____________________________________ ☐ SELF or ____ Relationship to patient: _______________

ID # ___________________________ GRP: ______________ DOB: ______________ EMPLOYER:_______________ SS#: _________________

WERE YOU REFERRED TO US? ☐ YES ☐ NO - IF YES, BY WHOM? ☐ DOCTOR ☐ FRIEND ☐ RELATIVE ☐ PHONE BOOK ☐ INSURANCE CO

NAME: ____

IF DOCTOR –Address: ________________________________ Phone: __________________ Fax: ______________________

PRIMARY CARE PHYSICIAN NAME:____

ADDRESS:____PHONE:______________________ FAX: ______________________________

INTERNIST/ CARDIOLOGIST NAME: ____Phone: _________________ Fax: ______________________

PREFERRED PHARMACY & PH NO : ____

ASSIGNMENT OF BENEFITS: I authorize my insurance company to pay my physician at Franciscan Physician Network directly for any benefits due me under the terms of my policy issued by your company. I will be responsible for the remaining deductibles, co-payments or balances due. I also authorize release of information acquired during my examination and treatment to the insurance company to facilitate payment.

SIGN HERE:____ (patient or guardian if minor)

Indiana Colon & Rectal Specialists –Member Franciscan Physician Network:

HEALTH HISTORY DATA SHEET

Patient Name:____ Date Completed: ____________

Date of Birth: ____________________ Weight: _____________________ Height: _____________________

Reason for this visit:

☐ Blood with bowel movement ☐ Constipation ☐ Abdominal pain
☐ Rectal pain ☐ Loose or frequent stools ☐ Nausea/vomiting
☐ Black tarry stools ☐ Change in bowel habits ☐ Abdominal bloating/cramping
☐ Other ____

Medical History

Gastrointestinal
☐ Colon cancer ☐ Colon polyps
☐ Ulcerative colitis
☐ Crohn's disease
☐ Inflammatory bowel disease

Cardiovascular
☐ Heart attack in past
☐ Congestive heart failure
☐ High blood pressure
☐ Pacemaker or Implanted Defibrillator : Type________________________ ~ Please provide card for copying.

Neurological
☐ Stroke or TIA
☐ Seizure disorder

Renal
☐ Renal insufficiency
☐ Renal failure
☐ Dialysis

Respiratory
☐ Emphysema ☐ COPD
☐ Asthma ☐Wheezing
☐ Obstructive sleep apnea

Endocrine
☐ Diabetes
☐ Thyroid disease
☐ Insulin-dependent
☐ Kidney stones

Other: ☐ AIDS/HIV positive ☐ Personal Diagnosis of Cancer: List Type: ______________________________

Have you taken Prednisone or Cortisone in the last three months? ☐ Yes ☐ No

Surgical History - *Please list surgical procedures you have had and approximately what year:*

☐ Gallbladder removed yr: _____ ☐ Cardiac stents yr: _____ ☐ __________________ yr:______
☐ Appendectomy yr: _____ ☐ Hysterectomy yr: _____ ☐ __________________ yr:______
☐ Tonsillectomy yr: _____ ☐ Tubal ligation yr: _____ ☐ __________________ yr:______
☐ Hernia repair yr: _____ ☐ Cesarean section yr: _____ ☐ __________________ yr:______
☐ **Colonoscopy** yr: ______ ☐ **Flexible Sigmoidoscopy** yr: _____ ☐ **Barium Enema** yr: _____

Medications - ☐ **Separate list provided** *Please list medication, dosage & frequency (include herbal medications):*

1. ____________________________ used for: ______________ 5. ____________________________ used for: ___________
2. ____________________________ used for: ______________ 6. ____________________________ used for: ___________
3. ____________________________ used for: ______________ 7. ____________________________ used for: ___________
4. ____________________________ used for: ______________ 8. ____________________________ used for: ___________

DO YOU HAVE A PAIN CONTRACT – Yes: ______ No: ______ DR: _________________________________

Are you currently prescribed any anticoagulants? (blood thinners) ☐ Yes ☐ No (if yes, mark below)

☐ Coumadin/Warfarin/Jantoven ☐ Plavix ☐ Pradaxa ☐ Aspirin ☐ Advil ☐ Aleve ☐ Other: __________

Medication Allergies

☐ NONE ☐ PENICILLIN ☐ SULFA ☐ CODEINE ☐ LATEX ALLERY

Other: 1.______________________ 2. ______________________3.______________________4.__________________

Reaction (please list which med) : ie: respiratory, hives, rash etc… ____

Social History

Do you smoke? ☐Yes ☐ No If yes: Packs per day: _____ for # of years:_____ -or- Smoke Free since: ______

Do you drink alcohol on a regular basis? ☐Yes ☐ No - If yes, how much per day? _______________________

What is your occupation? ___________________ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower

Family History - *Please check if your relatives have had:*

☐ Colon cancer – Relationship _______________ age of onset: _____ ☐ Colon polyps-Relationship_________

☐ Ulcerative colitis ☐ Crohn's disease ☐ Familial Polyposis

☐ Other Types of cancer ___________________________ Relationship ______________________

___________________________ Relationship ______________________

Review of Systems - *Please mark if you have had in the last year, or on a regular basis:*

Constitutional

☐ Persistent fever, chills
☐ Weight loss or gain
☐ Fatigue

Eyes

☐ Blurry or double vision
☐ Wear glasses or contacts
☐ Glaucoma

Ear, Nose, Mouth, Throat

☐ Hearing loss or ringing
☐ Ear aches
☐ Nose bleeding
☐Sore throat
☐ Mouth sores
☐ Swollen glands in neck

Cardiovascular

☐ Chest pain
☐ Heart murmur
☐ Palpitations
☐ Shortness of breath with walking
☐ Irregular heart beat
☐ Swelling of hands or feet

Integumentary

☐ Breast pain, lump, or discharge
☐ Rash or itching
☐ Skin problems

Respiratory

☐ Shortness of breath
☐ Wheezing
☐ Chronic cough
☐ Spitting up blood

Gastrointestinal

☐ Abdominal pain
☐ Nausea or vomiting
☐ Diarrhea
☐ Loss of appetite
☐ Accidental bowel leakage
☐ Blood in stool
☐ Painful bowel movements
☐ Change in stools

Genitourinary

☐ Frequent urination
☐ Painful urination
☐ Blood in urine
☐ Urinary incontinence
☐ Abnormal periods
☐ Kidney problems

Musculoskeletal

☐ Back pain
☐ Joint pain
☐ Joint swelling
☐ Muscle weakness

Neurological

☐ Frequent headaches
☐ Lightheadedness or dizziness
☐ Convulsions or seizures

Psychiatric

☐ Depression
☐ Anxiety
☐ Hallucinations
☐ Memory problems

Endocrine

☐ Glandular or hormone problem
☐ Thyroid disease
☐ Heat or cold intolerance
☐ Excessive thirst or urination

Allergic/Immunologic

☐ Adverse reaction to antibiotics
☐ Adverse reaction to narcotics
☐ Adverse reaction to anesthetics

Hematologic/Lymphatic

☐ Abnormal bleeding with surgery
☐ Blood disorder
☐ Anemia
☐ Blood clots in legs or lungs

DATE COMPLETED ______________ **PATIENT SIGNATURE**____