Franciscan PHYSICIAN NETWORK
CENTRAL INDIANA PROCTOLOGY

Registration Form

Date: _____

Patient Name: _____ Sex F_____ M _____
Last First MI
***Preferred First Name**: _____

Social Security # _____/_____/_____ Birthdate: _____/_____/_____ Age: _____

Address: _____
Street / Apt. # City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Preferred method of communication: Phone Mail MyChart message

Employer/School: _____ Occupation: _____

Address: _____ Phone: _____

Marital Status: M S D W Ethnicity: _____ Religion: _____ Race: _____

Spouse's Name: _____ Birthdate: _____ Employer: _____

Phone: _____ Cell phone: _____
(We especially need spouse information if you are covered on their insurance policy)

Medical Insurance Information:

First (Primary): _____ ID # _____
Insurance address: _____ Group # _____

Secondary: _____ ID # _____
Insurance address: _____ Group # _____

We will need to make copies of all insurance cards and photo ID

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Were you referred to our office: yes no if yes, by whom: _____

Primary Care Physician: _____**Would you like us to send copies of records: _____**

Referring Physician: _____**Would you like us to send copies of records: _____**

***Preferred Pharmacy Name:** _____ PH: (_____) _____

Street / location: _____
(WE NEED THIS TO SEND PRESCRIPTIONS ELECTRONICALLY TO THE PHARMACY)

Emergency Contact Name: _____

Relationship: _____ DOB:_____

Home Phone: _____ Cell Phone: _____

*Is your present condition due to events resulting strictly from employment: yes no
*Have you ever been a patient with Central Indiana Proctology before: yes no
*Have you ever had a colon exam before yes no
If so, where and when _____

Have you had stomach, chest or colon x-rays in the past 2 years: yes no

Height: _____

Weight: _____

Drug Allergies: _____ **Reaction:** _____
NONE ☐ _____ _____
_____ _____

Current Medications: NONE ☐

Name strength/dosage reason for taking
(You may provide a separate list)

_____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY: (circle all that apply)

General:
Diabetes
High Blood Pressure
Thyroid disease
HIV positive
Arthritis
High Cholesterol
Anemia

Urogenital
Prostate problems
Kidney Stones
Frequent urinary infections

Gastrointestinal:
Acid Reflux
Stomach ulcers
Diverticulosis
Irritable Bowel syndrome
Crohn's disease
Ulcerative Colitis
Colon polyps
Hemorrhoids
Hepatitis/ liver disease

Cardiac:
Heart attack
Congestive heart failure
Bypass/angio surgery
Valve disease
Atrial Fibrillation
Defibrillator Implant
Artificial Valves

Lungs:
Asthma
Blood clots
Pneumonia
Emphysema
Sleep Apnea

Neuropsychiatric:
Stroke
Seizure
Depression
Alzheimer's disease
Alcoholism
Drug / substance abuse

Surgeries: **Please check if you have:** **Year**

NONE ☐

Appendix removed	_____	_____
Gallbladder removed	_____	_____
Uterus removed	_____	_____
Ovaries removed	_____	_____
Tonsils/adenoids removed	_____	_____
Hemorrhoids removed	_____	_____

Other:_____

_____

Please list any hospitalizations for illness that did not require surgery: _____

_____

Do you take any blood thinning medication: _____ if so, name, dosage and strength: _____

(i.e. Coumadin, Warfarin, Xarelto, Effient, Plavix, Clopidogrel, Eliquis)

Reason: _____

Who Monitors: _____ Phone #_____

Family History: **Mother Living / Deceased ⇨ cause of death:** _____

Father Living / Deceased ⇨ cause of death: _____

Have you or any of your blood relatives Have or had:

Colon Cancer	yes	no
Colon polyps	yes	no
Crohn's disease	yes	no
Ulcerative Colitis	yes	no
Esophageal Cancer	yes	no
Stomach Cancer	yes	no

***Explain any "yes" answers**: _____

Health & Social History: **(circle one)**

Do you smoke:	**yes**	**no**
Do you chew tobacco:	**yes**	**no**
Do you drink alcohol:	**yes**	**no**
Do you take Aspirin	**yes**	**no**
Have you ever had a blood transfusion	**yes**	**no**
Do you consume caffeine	**yes**	**no**
Do you have any tattoo's	**yes**	**no**
Do you have any weight concerns	**yes**	**no**
Do you exercise routinely	**yes**	**no**
Do you have any body piercings	**yes**	**no**
Do you wear your seat belt	**yes**	**no**
Do you have any hobbies	**yes**	**no**
Do you have any occupational exposure	**yes**	**no**
Are you on a special diet	**yes**	**no**
Do you have any stress concerns	**yes**	**no**
E-Cigarettes or Vape	**yes**	**no**

former (quit date): _____

in the past: _____

in the past: ___ wine beer liquor

REVIEW OF SYMPTOMS: (ROS)
Please check if you have had any of these in the past six months:

Headaches	_____	Black Stools	_____
Fever	_____	Weight loss	_____
Shortness of breath	_____	Difficulty swallowing	____
Skin rashes	_____	Heartburn	_____
Dizziness	_____	Nose bleeds	_____
Vision changes	_____	Difficulty urinating	____
Nausea	_____	Constipation	____
Blood in stools	_____	Rectal pain	____
Diarrhea	_____	Chest pain	____
Stool Incontinence	_____	Mouth Sores	____
Diarrhea	_____		
Stool Incontinence	_____		

Other symptoms that concern you:

_____

_____

Are there any other current or past medical conditions we should be aware of:

_____

Have you ever had any type of cancer? Yes No where / when:

_____

Women only: Are you pregnant or trying to conceive? yes no
Are you breast feeding yes no

****What problems or concerns bring you to our office today:**

_____

_____

Routine Screening: ☐

Have you tried any home or drug store remedies for your current problem? _____

Patient signature: _____ Date: _____

Revised by patient: signature: _____ Date: _____

Office use only:

Reviewed by physician: _____ Date: _____
Revision reviewed by physician: _____ Date: _____
NPV approved: _____ Date: _____