BAPTIST HEALTH®
MEDICAL GROUP

Office Use Only	
Screening	☐
Recall	☐

Date: _____

Patient Name: Last_____ First_____

DOB_____

Any Known Allergies to medication/Latex?

_____

Have you ever had a colonoscopy? Yes No If yes, when and where?

Are you being referred because of a positive Cologuard? Yes No

Do you have a personal history of colon polyps? Yes No

Do you have a family history of colon polyps? Yes No

Do you have a family history of colon cancer? Yes No

Relationship and age of family member with Colon cancer: _____

Do you have or have you had any rectal bleeding in the past 6mos? Yes No

Do you use Oxygen? Yes No

Do you have a defibrillator? Yes No

Any previous surgeries (including EGD or Colonoscopy)?

_____

_____

Any past medical history that we should know about?

_____

_____

Please circle below all that you are currently taking:

Blood Thinners:

Aspirin	**Eliquis**	**Plavix/Clopidogel**	**Arixtra**	**Brillinta**
Coumadin/Warfarin	**Lovenox**	**Effient**	**Xarelto**	

NSAIDS:

Aleve	**Naproxen**	**Meloxicam**	**Motrin/Ibuprofen**	**Celebrex**	**Diclofenac**

Please list your current medications (include Herbs & Vitamins)

Medication **Strength** **Dose**

_____

_____

_____

_____

_____

_____

(You may continue the back side, if needed)

****Please include a copy of the front and back of your insurance card****

Please send completed form to the office of your choice:

Baptist Health Gastro Louisville
3950 Kresge Way
Louisville, KY 40207
Ph: 502-893-0220
FAX: 502-893-0563

Baptist Health Gastro Eastpoint
2400 Eastpoint Pkwy
Louisville, KY 40223
Ph: 502-928-8970
FAX: 502-928-8971

Baptist Health Gastro Lagrange
1031 New Moody Ln
Lagrange, KY 40031
PH: 502-222-6008
FAX: 502-225-5491

BAPTIST HEALTH MEDICAL GROUP **DATE: _____**

GASTROENTEROLOGY

Patient Name: _____ DOB: _____ SSN: _____

Marital Status: _____ Email: _____ Age: _____ Sex:_____

Address: _____

City, State and Zip code:_____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone:

Referring Physician: _____

Employer: _____ Phone: _____ Employment Status: (Circle one) FT · PT · Not employed ·

Military · Retired · Self-employed · Disabled · Student

Responsible Party: _____ Relation to Patient: _____

SSN: _____ DOB: _____ Primary Phone: _____

Address:_____ City: _____ State: ____ Zip: _____

Insurance Information Primary Insurance: _____

Policy #: _____ Group: _____ Effective Date: _____

Subscriber Name:_____ Subscriber SSN:_____ Subscriber DOB: _____

Relation to Patient: _____ Subscriber Address: _____

City, State and Zip Code _____

Secondary Insurance: _____ Policy# _____ Group: _____ _ Effective Date: _____

Subscriber Name: _____ Subscriber SSN: _____ Subscriber DOB: _____

Relation to Patient: _____ _ Subscriber Address: _____

City, State and zip code: _____