



Welcome to Midwest Gastrointestinal Associates, PC

Dear Patient:

An appointment has been scheduled for you on _____

with Doctor _____ at

17001 Lakeside Hills Plaza, Suite 200

Omaha, NE 68130

(map on reverse)

Phone (402) 885-8700

Fax (402) 397-6656

Please arrive for your appointment at _____ am/pm.

Your appointment is scheduled at _____ am/pm.

In an effort to make the registration process more efficient, please bring the following items to your appointment:

- Completed Midwest GI History Form (enclosed). This form contains valuable information and will assist the doctor in your care.
- Your insurance card(s) and photo ID.
- A list of your medications (to include prescription and over-the-counter), vitamins, supplements and herbs along with the dosage, and how often you take them.
- Signed Midwest GI Financial Policy (enclosed). It is important to us that you understand our policy so please read this carefully and if you have questions, do not hesitate to ask.
- Co-pay is expected to be paid at the time of service.

Again we would like to welcome you to Midwest Gastrointestinal Associates, PC.

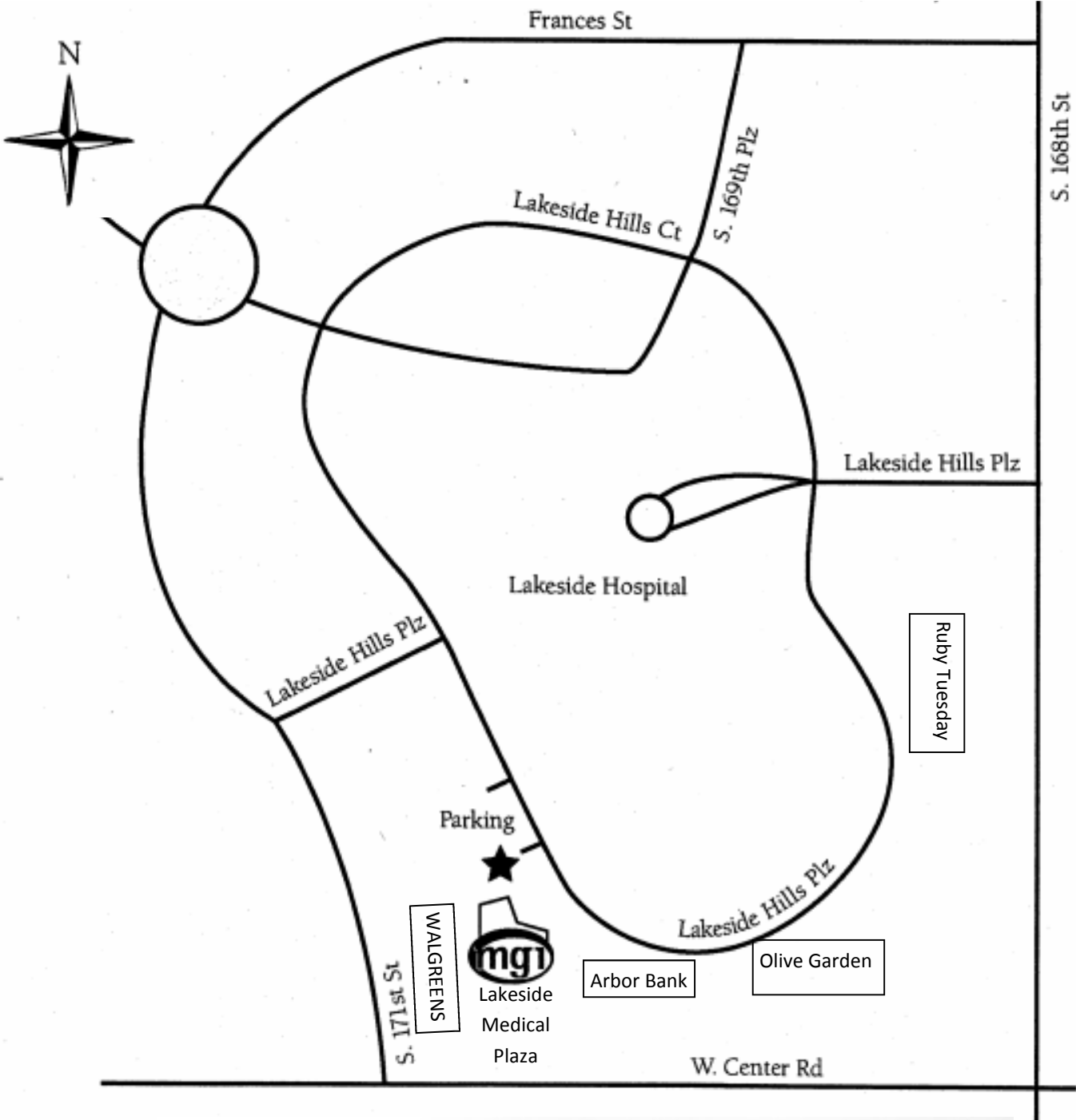
Sincerely,

Midwest Gastrointestinal Associates, PC



Midwest
Gastrointestinal
Associates PC

Lakeside Medical Plaza Building
17001 Lakeside Hills Plaza, Suite 200
Omaha, NE 68130
402-885-8700



Midwest Gastrointestinal Associates, PC
History Form
Please complete this form in full prior to your visit

NAME: _____ DOB: _____

DATE: _____ AGE: _____ SEX: M / F Primary Care Provider: _____

ALLERGIES TO MEDICATIONS: _____

Briefly describe why you came to our clinic today: _____

CURRENT MEDICATIONS TO INCLUDE OVER THE COUNTER AND/OR SUPPLEMENTS:

PRESCRIPTION MEDICATION NAME, DOSE (mg/units), FREQUENCY	PRESCRIPTION MEDICATION NAME, DOSE (mg/units), FREQUENCY

MEDICAL HISTORY

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <table style="width: 100%; border: none;"> <tr> <td style="width: 10%; text-align: center;">YES</td> <td style="width: 10%; text-align: center;">NO</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Irritable Bowel Syndrome</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Colon Polyp</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Colon Cancer</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Inflammatory Bowel Disease/Crohn's/Ulcerative Colitis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Barrett's Esophagus</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ulcers</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Esophageal Stricture</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Celiac Disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hiatal Hernia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Gallbladder Problems/Gallstones</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Liver Problems/Hepatitis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diverticulosis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diverticulitis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pancreas Problems</td> </tr> </table> | YES | NO | | <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | Colon Polyp | <input type="checkbox"/> | <input type="checkbox"/> | Colon Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Inflammatory Bowel Disease/Crohn's/Ulcerative Colitis | <input type="checkbox"/> | <input type="checkbox"/> | Barrett's Esophagus | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Esophageal Stricture | <input type="checkbox"/> | <input type="checkbox"/> | Celiac Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hiatal Hernia | <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder Problems/Gallstones | <input type="checkbox"/> | <input type="checkbox"/> | Liver Problems/Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Diverticulosis | <input type="checkbox"/> | <input type="checkbox"/> | Diverticulitis | <input type="checkbox"/> | <input type="checkbox"/> | Pancreas Problems | <table style="width: 100%; border: none;"> <tr> <td style="width: 10%; text-align: center;">YES</td> <td style="width: 10%; text-align: center;">NO</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Eosinophilic Esophagitis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Anal Fissures</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Anal Fistula</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hemorrhoids</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other GI Diseases Not Mentioned _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart Disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lung disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Endometriosis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ovarian Cysts</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Anemia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Anxiety</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Depression</td> </tr> </table> | YES | NO | | <input type="checkbox"/> | <input type="checkbox"/> | Eosinophilic Esophagitis | <input type="checkbox"/> | <input type="checkbox"/> | Anal Fissures | <input type="checkbox"/> | <input type="checkbox"/> | Anal Fistula | <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> | Other GI Diseases Not Mentioned _____ | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Lung disease | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis | <input type="checkbox"/> | <input type="checkbox"/> | Ovarian Cysts | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel Syndrome | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Colon Polyp | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Colon Cancer | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Inflammatory Bowel Disease/Crohn's/Ulcerative Colitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Barrett's Esophagus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Esophageal Stricture | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Celiac Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hiatal Hernia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder Problems/Gallstones | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Problems/Hepatitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diverticulosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diverticulitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Pancreas Problems | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Eosinophilic Esophagitis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anal Fissures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anal Fistula | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other GI Diseases Not Mentioned _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Ovarian Cysts | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Do you have or are you being treated for any other medical problem not listed above? _____

Date of last pelvic exam: _____

Date of onset of menopause: _____

Last menstrual period: _____

Number of pregnancies & children: _____

HAVE YOU EVER HAD AN OPERATION? IF YES, PLEASE LIST BELOW:

Date	Where	Type of operation and reason	Physician

Midwest Gastrointestinal Associates, PC
History Form
Please complete this form in full prior to your visit

REVIEW OF SYSTEMS

Are you currently experiencing (check all that apply):

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <table border="0"> <tr><td>YES</td><td>NO</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Loss of appetite</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Weight loss</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Increased fatigue</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Reflux/heartburn</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Sore throat/burning</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Difficulty swallowing pills or food</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Difficulty swallowing liquids</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Regurgitation of foods or liquids</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Nausea</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Vomiting</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Vomiting blood</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abdominal pain – location _____</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abdominal pain associated with meals</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abdominal pain relieved by a bowel movement</td></tr> </table> | YES | NO | | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite | <input type="checkbox"/> | <input type="checkbox"/> | Weight loss | <input type="checkbox"/> | <input type="checkbox"/> | Increased fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Reflux/heartburn | <input type="checkbox"/> | <input type="checkbox"/> | Sore throat/burning | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing pills or food | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing liquids | <input type="checkbox"/> | <input type="checkbox"/> | Regurgitation of foods or liquids | <input type="checkbox"/> | <input type="checkbox"/> | Nausea | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting blood | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain – location _____ | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain associated with meals | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain relieved by a bowel movement | <table border="0"> <tr><td>YES</td><td>NO</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bloating/gas</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>A change in your bowel habits</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Constipation</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diarrhea</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Alternate between constipation and diarrhea</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Feeling of bowels not emptying completely</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>A sense of urgency to empty your bowels</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Incontinence of bowel</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Rectal pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Rectal bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Black or tarry looking stools</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Mucus or pus in stools</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Jaundice (yellow eyes/skin)</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other symptoms _____</td></tr> </table> | YES | NO | | <input type="checkbox"/> | <input type="checkbox"/> | Bloating/gas | <input type="checkbox"/> | <input type="checkbox"/> | A change in your bowel habits | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Alternate between constipation and diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Feeling of bowels not emptying completely | <input type="checkbox"/> | <input type="checkbox"/> | A sense of urgency to empty your bowels | <input type="checkbox"/> | <input type="checkbox"/> | Incontinence of bowel | <input type="checkbox"/> | <input type="checkbox"/> | Rectal pain | <input type="checkbox"/> | <input type="checkbox"/> | Rectal bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Black or tarry looking stools | <input type="checkbox"/> | <input type="checkbox"/> | Mucus or pus in stools | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice (yellow eyes/skin) | <input type="checkbox"/> | <input type="checkbox"/> | Other symptoms _____ |
| YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight loss | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased fatigue | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Reflux/heartburn | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat/burning | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing pills or food | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing liquids | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Regurgitation of foods or liquids | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting blood | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain – location _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain associated with meals | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain relieved by a bowel movement | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| YES | NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloating/gas | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | A change in your bowel habits | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Alternate between constipation and diarrhea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling of bowels not emptying completely | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | A sense of urgency to empty your bowels | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinence of bowel | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rectal pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rectal bleeding | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Black or tarry looking stools | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Mucus or pus in stools | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice (yellow eyes/skin) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other symptoms _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Have you been seen by a Gastroenterologist before? No Yes Procedures Performed? _____

Name of MD/DO: _____ Dates: _____

Prior colorectal cancer screening: No Yes Location: _____

Results: _____

Last Colonoscopy: _____ Last Upper Endoscopy: _____

Recent X-Rays: _____ Where/When: _____

Recent Blood Work: _____ Where/When: _____

FAMILY HISTORY (check all that apply):

If answered Yes, please indicate family member(s) (GM=Grandmother, GF=Grandfather, M=Mother, F=Father, B=Brother, S=Sister, U=Unknown, O=Other)

- | YES | NO | Who | YES | NO | Who |
|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Colon Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Colon polyps | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding/Clotting Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Pancreatic Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Hemochromatosis (excess iron) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pancreatitis | <input type="checkbox"/> | <input type="checkbox"/> | Gallstones |
| <input type="checkbox"/> | <input type="checkbox"/> | Crohn's Disease | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcerative colitis | <input type="checkbox"/> | <input type="checkbox"/> | Cancer: Type _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Celiac Disease | | | |

Do you follow a special diet? No Yes If yes, explain: _____

Have you traveled outside the United States in the last six months? No Yes, where: _____

Any illness associated with travel? No Yes

Have you ever experienced abuse? No Yes

- | | | | | |
|-----------------------|---------------------------------------|--|--|-------------------------------------|
| Alcohol Use: | <input type="checkbox"/> Use Everyday | <input type="checkbox"/> Use Some Days | <input type="checkbox"/> Used Formerly | <input type="checkbox"/> Never Used |
| Caffeine Use: | <input type="checkbox"/> Use Everyday | <input type="checkbox"/> Use Some Days | <input type="checkbox"/> Used Formerly | <input type="checkbox"/> Never Used |
| Marijuana/Cannabis: | <input type="checkbox"/> Use Everyday | <input type="checkbox"/> Use Some Days | <input type="checkbox"/> Used Formerly | <input type="checkbox"/> Never Used |
| Recreational Drugs: | <input type="checkbox"/> Use Everyday | <input type="checkbox"/> Use Some Days | <input type="checkbox"/> Used Formerly | <input type="checkbox"/> Never Used |
| Tobacco Use: | <input type="checkbox"/> Use Everyday | <input type="checkbox"/> Use Some Days | <input type="checkbox"/> Used Formerly | <input type="checkbox"/> Never Used |
| Vape/E-Cigarette Use: | <input type="checkbox"/> Use Everyday | <input type="checkbox"/> Use Some Days | <input type="checkbox"/> Used Formerly | <input type="checkbox"/> Never Used |

MIDWEST GASTROINTESTINAL ASSOCIATES, P.C.
FINANCIAL POLICY

We would like to take the opportunity to welcome you to our facility and to let you know that we are committed to providing you the best possible care. Thanks in advance for reading this information as it's critical that you understand our Financial Policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

We are here to assist you in providing information to your Health Insurance Company so that payment may be made according to the coverage you have purchased. Please keep in mind that not all services are a covered benefit in all Plans and that your insurance coverage is an agreement between you and your Health Insurance Company. Payment for services at Midwest Gastrointestinal Associates, P.C., is ultimately the patient's responsibility.

<p>If you are scheduled for a screening colonoscopy: The Facility submits procedural documentation and charges according to Centers for Medicare and Medicaid Services and American Medical Association guidelines and is not responsible for determining how your benefits will be paid by your insurance plan. Please keep in mind that all charges may not be covered under your screening and health preventive benefits. If you have questions please call us at (402) 504-3846 for a more detailed explanation.</p>
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Providing you have insurance, we will file your primary and secondary insurance for you as a courtesy, provided we have your assignment of benefits as well as a copy of your insurance card(s) identifying your primary and secondary coverage if applicable.

If your Insurance Plan requires an authorization for care or treatment, it is the patient's responsibility to obtain one prior to your visit. Contact your Insurance Carrier if you are not sure. If a referral is not obtained, your insurance company may deny payment coverage and could result in patient responsibility.

Patient deductibles, coinsurance and co-payment amounts are established by your Health Plan and are your responsibility.

Prompt payment of your account is expected; however, we realize that situations may arise whereby you may have difficulty meeting your obligation. If such problems do arise, we encourage you to contact us for assistance in the management of your account. We do use outside agencies as a means of collection should your account become delinquent.

Patients who fail to provide insurance information are directly responsible for payment of their account.

If you don't have insurance, acceptable financial arrangements will need to be determined prior to the date of service. An account representative will be happy to assist you and can be reached at (402) 397-7057. Please note a deposit will be required at the time of visit.

You will be billed a professional fee for the services provided by the physician's of Midwest Gastrointestinal Associates, P.C. You may also receive a bill for facility fees in the event you have a procedure done outside the offices of Midwest Gastrointestinal Associates, P.C. In addition, if lab work is necessary you may receive a separate billing for those services.

For your convenience, checks, cash, Visa, MasterCard, Discover, American Express and debit cards are accepted.

AUTHORIZATION

I have read and agree to the terms and conditions listed above and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to Midwest Gastrointestinal Associates, P.C. I understand I am financially responsible to Midwest Gastrointestinal Associates, P.C. for charges not covered or denied by my insurance company. A photocopy of this agreement shall be valid as the original. This authorization is to remain in effect until revoked in writing by me or my legal representation.

Signature

Date