GASTROENTEROLOGY

Sonoma Valley Specialty Clinic • 347 Andrieux St, Ste 28, Sonoma, CA 95476
Patrick I. Okolo III, MD, MPH • (707) 939-7690

PATIENT INTAKE FORM
Date: ____________________
Chart #: _________________

PATIENT DEMOGRAPHICS

Last Name	First Name
Date of Birth (MM/DD/YYYY)	Preferred Name / Nickname
Address	City, State, ZIP
Home Phone	Cell Phone
Email Address	Preferred Contact Method
Emergency Contact Name	Emergency Contact Phone

Sex Assigned at Birth	Gender Identity	Race / Ethnicity
☐ Male ☐ Female ☐ Intersex	☐ Man ☐ Woman ☐ Nonbinary ☐ Prefer not to say	☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Other

INSURANCE INFORMATION

Primary Insurance Company	Policy / Member ID
Group Number	Insurance Phone Number
Policyholder Name (if not patient)	Policyholder Date of Birth
Secondary Insurance Company (if any)	Secondary Policy / Member ID

REFERRING PROVIDER

Referring Provider Name	Practice / Clinic
Phone	Fax

Primary Care Physician Name	PCP Phone

REASON FOR VISIT

Chief Complaint / Reason for Today's Visit:

How long have you had this problem?

Please check all GI symptoms that apply:

☐ Abdominal pain ☐ Bloating / gas ☐ Nausea ☐ Vomiting
☐ Diarrhea ☐ Constipation ☐ Blood in stool ☐ Black/tarry stool
☐ Heartburn / reflux ☐ Difficulty swallowing ☐ Loss of appetite ☐ Unintended weight loss
☐ Rectal bleeding ☐ Hemorrhoids ☐ Jaundice (yellowing) ☐ Other: ________________

GASTROINTESTINAL HISTORY

Prior GI Diagnoses (check all that apply):

☐ GERD / Acid reflux ☐ Peptic ulcer disease ☐ Barrett's esophagus ☐ Celiac disease
☐ Crohn's disease ☐ Ulcerative colitis ☐ Irritable bowel syndrome (IBS) ☐ Diverticulosis/itis
☐ Colorectal polyps ☐ Colorectal cancer ☐ Liver disease ☐ Pancreatitis
☐ Gallbladder disease ☐ Hepatitis B ☐ Hepatitis C ☐ Other: ________________

Prior GI Procedures:

Procedure	Approximate Date	Location / Provider
Colonoscopy		
Upper endoscopy (EGD)		
Capsule endoscopy		
ERCP		
Other GI surgery		

PAST MEDICAL & SURGICAL HISTORY

Please list significant medical conditions:

Please list prior surgeries (non-GI):

CURRENT MEDICATIONS

Medication Name	Dose	Frequency	Reason

ALLERGIES

Allergen (medication, food, environmental)	Reaction

No known drug allergies ☐ No known allergies of any kind ☐

SOCIAL HISTORY

Tobacco use: ☐ Never ☐ Former (quit year: ______) ☐ Current — packs/day: ______

Alcohol use: ☐ Never ☐ Social / occasional ☐ Regular — drinks/week: ______

Recreational drugs: ☐ Never ☐ Former ☐ Current — type: ______________________________

Occupation: ____

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FAMILY HISTORY

Please indicate any family history of the following (note relationship):

☐ Colorectal cancer Relation: ____________	☐ Colorectal polyps Relation: ____________	☐ IBD (Crohn's / UC) Relation: ____________
☐ Liver disease Relation: ____________	☐ Celiac disease Relation: ____________	☐ Other GI cancer Relation: ____________

FOCUSED REVIEW OF SYSTEMS

In the past 3 months, have you experienced any of the following?

Unintentional weight loss of more than 10 lbs	☐ Yes ☐ No	*If yes, details:*
Fever (temperature > 101°F / 38.3°C)	☐ Yes ☐ No	*If yes, details:*
Night sweats	☐ Yes ☐ No	*If yes, details:*
Fatigue significantly affecting daily activities	☐ Yes ☐ No	*If yes, details:*
Blood in vomit or coffee-ground material	☐ Yes ☐ No	*If yes, details:*
Blood in stool (bright red or dark/tarry)	☐ Yes ☐ No	*If yes, details:*
Jaundice (yellowing of skin or eyes)	☐ Yes ☐ No	*If yes, details:*
Chest pain or pain with swallowing	☐ Yes ☐ No	*If yes, details:*
New or changing abdominal mass	☐ Yes ☐ No	*If yes, details:*

PATIENT AUTHORIZATION & SIGNATURE

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I authorize Sonoma Valley Hospital Gastroenterology to use this information for treatment, billing, and coordination of care purposes. I understand that this form will be kept confidential as part of my medical record.

Patient / Guardian Signature: ______________________________ **Date:** ______________________

Relationship to patient (if guardian): ______________________________ Staff initials (form received): __________