Scope Center of Peak Endoscopy
2920 North Cascade Ave, Ste 100
Colorado Springs, CO 80907
(719) 362-2300

Peak Gastroenterology Associates
2920 North Cascade Ave, Ste 300
Colorado Springs, CO 80907
Main Ph (719) 636-1201
&
1370 Interquest Pkwy, Ste 320
Colorado Springs, CO 80921

Optum Peak Endoscopy Center
1615 Medical Center Pointe
Colorado Springs, CO 80907
(719) 895-9090

PATIENT DEMOGRAPHICS

Legal Name:______________________________________ DOB: _________________ Age: ________

Address: ____ SSN: _____-_____-_____

City: ____________________ State: _____ Zip:________ Email:__________________________________

Phone: (H)_________________ (C)_________________ Sex: ☐ Male ☐Female

Marital Status: __________Ethnicity/Race:______________ Primary Doctor: ____________________________

Employer:____ Referring Doctor: __________________________

Preferred Language(s): ____

EMERGENCY CONTACT

Name: ______________________________ Relationship: __________________Phone: ________________________

INSURANCE INFORMATION

Primary Insurance: ________________________________ ID #: ______________

Policy Holder, if not patient: _________________________ DOB: ______________ SSN: _____-_____-_____

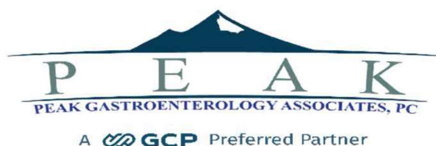
Secondary Insurance: ______________________________ID #: ________________

Policy Holder, if not patient: _________________________ DOB: ______________ SSN: _____-_____-_____

If patient is under 18 years old, please fill out information regarding parent/guardian accompanying minor child

Name: ___________________________Relationship: _____________ DOB:__________ SSN:______-______-______

Address: ______________________________ C i t y :______________________ State:________ Z i p : ___________



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PHONE MESSAGE CONSENT

By providing a telephone number, whether cellular or otherwise, to Peak Gastroenterology Associates, PC (PGA) now or at a later time, I consent to receiving telephone calls, voicemails and/or text messages, or other communication using live, artificial, or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from PGA, and its Affiliates. Affiliates include my health care providers, business associates, agents, contractors, vendors, assigns, successors, servicers, and collection agencies. I certify, warrant, and represent that I am authorized to receive calls at any of the telephone numbers I have provided. The text messages and phone calls may be related to any purpose, including related to my account and my health care, like appointment reminders or offers for additional services. I understand that standard text messaging rates may apply. I agree that PGA and my health care providers may share with Affiliates any telephone number(s) I provide to PGA, so that the Affiliate(s) may make the calls or texts on behalf of PGA or my health care provider. I understand that I may revoke my consent to receive such calls and texts at any time. The callers may leave the name of the company making calls or reference whom the caller is representing. By providing an email address, I give PGA, and Affiliates permission to contact me by email about mine or my dependents' health care or costs related to health care using any email address I provide. Affiliates may use any email address or phone number I give to PGA or that they obtain from me.

Home Phone: ______________________________ **Cell:** ______________________________

Work Phone: ______________________________ **Email:** ______________________________

My spouse or other family names and numbers I give permission to leave messages with and/or discuss my medical history:

Name/Relationship: ____________________/________________**Phone:** ____________________

Name/Relationship: ____________________/________________**Phone:**____________________

Name/Relationship: ____________________/________________**Phone:**____________________

PATIENT'S LEGAL NAME:____

Signature: ____

If legally authorized representative, then relationship to patient:__________________________

Date:________________________

PRIOR PROCEDURES

EGD Results:____ Date: ___________________

PRIOR PROCEDURES

Colonoscopy Results:____Date: ___________________

Sigmoidoscopy Results: ____ Date: ___________________

Capsule Endoscopy Results: ____ Date: ___________________

PAST MEDICAL HISTORY: *Please write in ALL medical problems you have*

1)	2)	3)	4)
5)	6)	7)	8)
9)	10)	11)	12)

PAST SURGICAL HISTORY: *Please write in ALL surgeries you have undergone.*

1)	2)	3)	4)
5)	6)	7)	8)
9)	10)	11)	12)

FAMILY HISTORY: *Please check the box below for "yes"*

Do family members have a history of:

☐ Celiac Disease	☐ Colon Cancer	☐ Cirrhosis	☐ Pancreatitis
☐ Pancreatic Cancer	☐ Crohn's Disease	☐ Ulcerative Colitis	☐ Stomach Cancer
☐	☐	☐	☐

SOCIAL HISTORY:

Smoking: YES or NO Packs per day: ______________# of Years:__________ Quit Date: ________________

Alcohol: YES or NO Beverage and # per day/week:____________________ Quit Date: ________________

Illicit Drugs: YES or NO Drugs Used:___________________________________ Quit Date: ________________

Tattoos: YES or NO Exercise: YES or NO

Marijuana: YES or NO Amount per day/week:___________________________

HX OF/OR CURRENT INFECTIOUS DIAGNOSIS: ☐MRSA ☐VRE ☐C-Diff

OTHER PERTINENT INFORMATION

____

____

Pharmacy/Location: ____ Phone: ______________________

MEDICATIONS

Please list ALL medications you are taking to include over-the-counter medications and herbal supplements. Please do not write "see attached list."

Prescription Medications

				For Office Use Only	
Name of Medication	Dose	Frequency	Reason for Medication	Continue	Discontinue

Over The Counter Medications or Herbal Supplements

				For Office Use Only	
Name of Medication	Dose	Frequency	Reason for Medication	Continue	Discontinue

ALLERGIES: Please list all your medication allergies

FOR FREC/SCOPE OFFICE USE ONLY

- ☐ Resume all pre-procedure medications
- ☐ New medications and instructions
- ☐ Patient received copy

Name of Medication	Dose	Frequency	Reason for Medication

Ride: ______________________________

Nurse: ______________________________

Physician: ______________________________

Date/Time: ______________________________

Patient Label Here

PEAK
PEAK GASTROENTEROLOGY ASSOCIATES, PC
A GCP Preferred Partner

REVIEW OF SYSTEMS

Please circle if you are experiencing any of these.

DO YOU SUFFER FROM HEMORRHOIDS? YES NO

CONSTITUTION	EYES	GENITOURINARY	NEUROLOGICAL
Activity Change	Eye Discharge	Difficulty Urinating	Dizziness
Appetite Change	Eye Itching	Pain with Urination	Facial Asymmetry
Chills	Eye Pain	Involuntary Urination	Headaches
Sweats	Eye Redness	Flank Pain	Lightheadedness
Fatigue	Light Sensitivity	Frequent Urination	Numbness
Fever	Vision Changes	Blood in Urine	Seizures
Weight Change	**RESPIRATORY**	Urine Urgency	Speech Difficulty
HEENT	Sleep Apnea	Decreased Urine	Passing Out/Syncope
Facial Swelling	Chest Tightness	Genital Sore	Tremors
Neck Pain	Choking	Penile Discharge	Weakness
Neck Stiffness	Cough	Penile Pain	**HEMATOLOGIC**
Ear Discharge	Shortness of Breath	Penile Swelling	Large Lymph Nodes
Hearing Loss	Stridor	Scrotal Swelling	Easy Bruising/Bleeding
Ear Pain	Wheezing	Testicular Pain	**PSYCHIATRIC**
Ringing In Ear	**CARDIOVASCULAR**	Vaginal Bleeding	Agitation
Nosebleeds	Chest Pain	Vaginal Discharge	Behavior Problems
Nasal Congestion	Leg Swelling	Vaginal Pain	Confusion
Runny Nose	Palpitations	**MUSCULOSKELETAL**	Poor Concentration
Postnasal Drip	**GI**	Joint Pain	Sadness
Sneezing	Abdominal Bloating	Back Pain	Hallucinations
Sinus Pressure	Abdominal Pain	Gait Problem	Hyperactive
Dental Problem	Anal Bleeding	Joint Swelling	Nervousness/Anxious
Drooling	Blood in Stool	Muscle Pain	Self-Injury
Mouth Sores	Constipation	**SKIN**	Disturbed Sleep
Sore Throat	Diarrhea	Color Change	
Trouble Swallowing	Nausea	Pallor	
Voice Change	Rectal Pain	Rash	
	Vomiting	Wounds	
	Fecal Incontinence		

THANK YOU FOR CHOOSING _PEAK GASTROENTEROLOGYASSOCIATES!_