Gastroenterology Center of Salem

A Service of SALEM REGIONAL MEDICAL CENTER

William Z. Kolozsi, M.D., M.S. **Meredythe A. McNally, M.D.**
Lorraine Cresanto, CRNP **LeeAnn Hritz, ANP-c**
2020 East State Street, Suite H
Salem, OH 44460
(330) 337-8709

YOUR APPOINTMENT: _____
(Please call if you are unable to keep this appointment)

We do ask that you bring your insurance card and any co-pays with you to your visit. If you are a self-pay patient you will be required to pay at the time of the visit. We accept cash, check, Master Card, Visa & Discover.

Please be aware that if you are uninsured a self-pay discount will be applied to all physician services you receive at the Gastroenterology Center of Salem.

However, for uninsured patients, it is the policy of the SCH Professional Corporation that the office visit must be paid at the time of service and if any procedures are scheduled a pre-surgical payment must be made on the day we schedule you for your procedure.

If you DO NOT have insurance you will need to bring a total of $300 on the day of your visit. This amount will cover the office visit which will be up to $100 and if a procedure needs scheduled $200 will be applied as a pre-surgical down payment.

Please complete all of the paperwork and return in the enclosed postage paid envelope **immediately**, as it will become a permanent part of your medical record. If we do not receive this information you may be asked to reschedule your appointment. All information is considered confidential.

OFFICE LOCATION:
We are located in the Columbiana Medical Center at 750 East Park Avenue, Suite A (2nd Floor) in Columbiana, Ohio.

If you have any questions, please call the office at (330) 337-8709.

Sincerely,

The Staff of the Gastroenterology Center of Salem

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The HIPAA Privacy Act was passed to protect your rights to privacy concerning your medical information. Federal law requires that we have your signature on file in your chart instructing us as to how to handle your medical information. Include the names of any family members, family doctor or other medical personnel that you permit to be informed of your medical information. Do not assume that our staff knows whom we can speak to regarding your medical information.

I,_____ , authorize Gastroenterology Center of Salem to provide my medical information to:

_____

_____

_____

_____

_____

This will be effective until I amend this release, or one year from the date of signing.

Signature:_____Date:_____

SCH Professional Corporation
A Service of SALEM REGIONAL MEDICAL CENTER

Patient Portal Invitation Information

First Name: _____

Last Name: _____

Date of Birth: _____

Email Address: _____

You will be required to enter a Security Code during registration; your security code will be the last 4 digits of your Social Security Number. Please inform the person at the front desk if you would prefer to create your own Security Code.

GASTROENTEROLOGY CENTER OF SALEM

PATIENT INFORMATION

Patient's Full Name:_____ Birth date:_____ Sex: M___ F___

Address:_____City:_____ State:_____ Zip:_____
Telephone:
Home:_____ Work:_____ Cell:_____

Social Security Number:_____ Marital Status: _____

In Case Of Emergency Notify: _____ Relationship:_____
Telephone:_____

Family Physician:_____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Name:_____ Relationship: _____
Birth date:_____ Social Security Number:_____
Address if different than above:_____
Telephone: _____

INSURANCE INFORMATION

Primary **Secondary**

Insurance Company: _____
Certificate # :_____
Group Number: _____
Group Name:_____
CoPay:_____
Subscriber Name:_____
Subscriber Birth date:_____
Relationship to Patient:_____

- I consent to the appropriate treatment for the patient's condition.
- I hereby authorize direct payment of surgical/medical benefits to SCH Professional Corporation for services rendered by Gastroenterology Center of Salem in person or under physician supervision.
- I understand that I am financially responsible for my health insurance deductibles, co-insurance and any other charges not paid by my insurance and that payment is due at the time service is rendered.
- I authorize SCH Professional Corporation to release any medical information that may be necessary for either medical care or in processing applications for financial benefit.

Signature:_____ Date: _____
(Patient, or guardian if a minor)

Please list all HEALTH PROBLEMS you have (under a Dr's care) or have had

Onset Date	Medical Condition	Date Resolved if not active

Please list all SURGERIES, HOSPITALIZATION and PROCEDURES

Date	Surgery – Hospitalization – Procedure	Location

Please list all MEDICATIONS you are taking, including Over The Counter Products

Medication	Dosage	How Taken

Please list all Allergies you may have – MOST IMPORTANT – ALL DRUG ALLERGIES

Item	Reaction

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Date:_____

PATIENT QUESTIONNAIRE

Patient Name:_____ D.O.B.:_____

Reason for Visit:

SYMPTOMS SURVEY

Instructions: Place a 1, 2 or 3 in the box depending upon the severity of the complaint. If it is "never", leave the box blank. USE: **(1)** for mild or seldom; **(2)** for moderate or occasional; and **(3)** for frequent or severe.

SECTION I

[ ] "Whites of eyes (sclera) yellow
[ ] Double or blurred vision
[ ] Headache over eyes – may last 3 to 4 hours
[ ] Head congestion/ "sinus fullness"
[ ] Coated tongue or "fuzzy" debris on tongue
[ ] Eyes and nose watery
[ ] Eyes swollen and puffy
[ ] Sneezing attacks
[ ] Bad breath, halitosis
[ ] Headaches when awaken – wear off during the day
[ ] Hoarseness – prolonged
[ ] Sore Throats – frequent
[ ] Thyroid Disease
[ ] "Lump" in throat
[ ] Dry mouth – eyes – nose
[ ] Burning sensation in mouth
[ ] Hearing difficulty
[ ] Afternoon headaches
[ ] Nosebleeds frequently
[ ] "Splitting" type headaches
[ ] Glaucoma
[ ] Hoarseness – frequent
[ ] Ulcers – Mouth

SECTION II

[ ] Blood pressure low
[ ] Circulation poor
[ ] Shortness of breath with exertion
[ ] Dull pain in chest or radiating into left arm - worse on exertion
[ ] Chest pain with exertion
[ ] Chest pain at rest
[ ] Subject to colds, asthma, bronchitis
[ ] Bronchitis
[ ] Heart Failure
[ ] Heart Murmur
[ ] Enlarged heart and/or heart failure
[ ] Pulse speeds after meals and/or heart pounds after retiring
[ ] Heart palpitations
[ ] Irregular heart rate
[ ] High Blood Pressure
[ ] Heart Attack
[ ] Heart Disease
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Tuberculosis
[ ] Asthma
[ ] Aware of heavy and/or irregular breathing
[ ] Discomfort in high altitudes, worse on exertion

SECTION III

[ ] Loss of muscle tone or "heaviness" in arms or legs.
[ ] Arthralgias (joint pains)
[ ] Arthritis
[ ] Frequent skin rashes and/or hives
[ ] Muscle-leg-toe cramping at rest and/or while sleeping
[ ] Numbness in hands and feet (extremities "go to sleep")
[ ] Arthritic tendencies
[ ] Muscle cramps, worse with exercise ("charley horses")
[ ] Joint stiffness after rising
[ ] Migrating aches and pain.
[ ] Nails weak, ridges
[ ] Muscular and nervous exhaustion
[ ] Muscle soreness after moderate exercise
[ ] Vulnerability to insect bites – especially fleas & mosquitoes
[ ] Perspire easily
[ ] Gout
[ ] Back Pain

SECTION IV

[ ] Premenstrual tension
[ ] Painful menses
[ ] Menstruation excessive or prolonged
[ ] Painful – tender breasts
[ ] Prostate trouble

[ ] Urination difficult or dribbling
[ ] Night urination frequent
[ ] Menses scanty or missed
[ ] Hysterectomy / ovaries removed
[ ] Menopausal hot flashes
[ ] Hair growth on face or body (for FEMALES)
[ ] Masculine tendencies (FEMALES)
[ ] Kidney Failure
[ ] Kidney Stones
[ ] Blood in Urine
[ ] Menstrual disorders (Women)
[ ] Lack of menstruation (young girls)

SECTION V

[ ] Worrier, feel insecure and/or highly emotional
[ ] Chronic fatigue / get drowsy
[ ] Afternoon yawning
[ ] Weakness / dizziness
[ ] Anxious or Anxiety
[ ] Depression
[ ] Nervous, emotional, and/or can't work under pressure
[ ] Insomnia
[ ] Inward trembling
[ ] Night sweats
[ ] Eat when nervous
[ ] Irritable before meals
[ ] Get "shaky" or light-headed if meals delayed
[ ] Fatigue relieved by eating
[ ] Heart palpates if meals missed or delayed
[ ] Awaken a few hours after sleep, hard to get back to sleep
[ ] Mental Illness
[ ] Nervousness
[ ] Palpitations
[ ] Phobias
[ ] Sex drive reduced or absent
[ ] Sex drive increased
[ ] Low self esteem
[ ] Lack of motivation
[ ] Memory failing
[ ] Slow starter in the morning

SECTION VI

[ ] Alcoholism
[ ] Allergies – general
[ ] Allergies – food
[ ] Allergies and/or hives
[ ] Anemia
[ ] Appetite reduced
[ ] Convulsions
[ ] Bruise easily, "black and blue" spots
[ ] Fainting Spells
[ ] Falling frequently
[ ] Dizzy Spells
[ ] Cancer
[ ] Hungry between meals or excessive appetite
[ ] Diabetes (sugar trouble)
[ ] Stroke
[ ] Fever easily raised – fevers common
[ ] Tremors
[ ] Intolerant to cold temperatures
[ ] Intolerant to hot temperatures
[ ] Abnormal thirst

SECTION VII

[ ] "Acid" breath
[ ] Burning (acid) or nervous stomach relieved by food
[ ] Gas shortly after eating
[ ] Indigestion ½ to 1 hour after eating - may last 3 to 4 hours
[ ] Difficulty digesting fruits or vegetables – undigested foods found in stools
[ ] Acid or spicy foods upset stomach
[ ] Lower bowel gas and or bloating several hours after eating
[ ] Pass large amounts of foul smelling gas
[ ] Irritable bowel or mucous colitis
[ ] Constipation – diarrhea alternating or stools alternate from soft to watery
[ ] Bowel movements painful or difficult, constipation and/or laxative used
[ ] Burning or itching anus
[ ] Tendency to ulcers or colitis
[ ] Difficulty swallowing
[ ] Vomiting frequently
[ ] Intolerant to monosodium glutamate (MSG)
[ ] Ulcers – Duodenal / Peptic
[ ] Ulcers – Stomach
[ ] Inflammatory Bowel Disease
[ ] Heartburn
[ ] Hemorrhoids
[ ] Hepatitis
[ ] Hernia
[ ] Bright Red Rectal Bleeding
[ ] Diarrhea – Chronic
[ ] Diarrhea – Intermittent
[ ] Constipation
[ ] Change in Bowel Habits
[ ] Colitis
[ ] Diverticulosis
[ ] Indigestion
[ ] Gall Bladder Trouble
[ ] Jaundice
[ ] Abnormal Liver Tests

PLEASE LIST ANY MEDICAL CONDITIONS THAT MAY NOT HAVE BEEN LISTED:

FAMILY HISTORY

Please check any conditions that exist in your family

- ☐ Alcoholism
- ☐ Allergies – general
- ☐ Allergies – food
- ☐ Anemia
- ☐ Arthralgias (joint pains)
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Colitis
- ☐ Constipation
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes (sugar trouble)
- ☐ Diarrhea – Chronic
- ☐ Diarrhea – Intermittent
- ☐ Dizzy Spells
- ☐ Diverticulosis
- ☐ Double or blurred vision
- ☐ Fainting Spells
- ☐ Falling frequently
- ☐ Fatigue – Chronic
- ☐ Gall Bladder Trouble
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heartburn
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel
- ☐ Liver Disease
- ☐ Jaundice (turning yellow)
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Mental Illness
- ☐ Nervousness
- ☐ Palpitations
- ☐ Phobias
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sleeping difficulty
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tremors
- ☐ Tuberculosis
- ☐ Ulcers – Duodenal /Peptic
- ☐ Ulcers – Stomach

Please list any family medical conditions that may not have been listed:

If there is a family history of cancer, please indicate type (s) and relationship (s) to you:

If any brothers or sisters have died, please list age and cause:

Mother: ☐ Living ☐ Deceased - If deceased, please indicate age and cause:

Please indicate your mothers' medical history:

Father: ☐ Living ☐ Deceased - If deceased, please indicate age and cause:

Please indicate your fathers' medical history:

SOCIAL HISTORY

☐ Single ☐ Married ☐ Widowed

☐ Separated ☐ Divorced ☐ Other

Number of Children: _____

Occupation: _____

Work Hours: _____ Swing Shift: ☐ Yes ☐ No

Stress on the Job: ☐ Little ☐ Moderate ☐ Severe

Do you like your Job: ☐ Yes ☐ No ☐ Other: _____

If married, please indicate the occupation of your spouse: _____

Are any Chemicals used on your job: ☐ No ☐ Yes → Name them if you can:_____
_____

Do you drink Coffee: ☐ No ☐ Yes → Cups per day: _____ Type: ☐ Regular ☐ Decaff

Do you drink Pop: ☐ No ☐ Yes → cans/bottles per day: _____ Type: ☐ Regular ☐Diet ☐ Caffeine free

Do you drink Milk: ☐ No ☐ Yes → Amount per day: _____

Do you use artificial sweeteners: ☐ No ☐ Yes → Type: _____

Do you Smoke: ☐ No ☐ Stopped → When: _____ ☐ Yes → Type, packs per day and how long: _____

Do you drink Alcohol: ☐ No ☐ Stopped → When: _____ ☐ Yes → Type, average per week and how long: _____

Do you Abuse Drugs: ☐ No ☐ Stopped → When: _____ ☐ Yes → Type, average per week and how long:_____

Do you Exercise: ☐ No (couch potato) ☐ Yes → Type, average times per week and how long:_____
_____

What is your favorite exercise:_____

What is your favorite meal including all courses:_____
_____

What is your favorite fruit: _____

What is your favorite vegetable: _____

What is your favorite dessert: _____

What is your favor hobby: _____

What is your favorite outdoor location: _____

Do you like: Being out in the sun: ☐ No ☐ Yes
Being outdoors: ☐ No ☐ Yes
To garden: ☐ No ☐ Yes

Please check if you eat, drink or use:

☐ Distilled Water
☐ Lunch Meats
☐ Non-Herbal Teas
☐ Candy
☐ Florinated and/or chlorinated water
☐ Margarine
☐ Chew Tobacco
☐ Carbonated beverages
☐ Fast Food frequently
☐ Refined Sugars
☐ Vitamins & Minerals
☐ Fried Food
☐ Refined white flour products
☐ Diet often
☐ Exercise less than 3 times per week
☐ Salt food without tasting
☐ Are under excessive stress
☐ Exposed to cigarette smoke

THE FOLLOWING SECTION IS OPTIONAL

Do you believe in the power of the mind: ☐ No ☐ Yes

Do you believe in a Divine Being or Object: ☐ No ☐ Yes

Do you want to be healthy: ☐ No ☐ Yes

Do you believe that you can become healthy: ☐ No ☐ Yes

Do you have pain with your current condition: ☐ No ☐ Yes → Location:_____

How severe is the pain (describe): _____

What makes the pain worse: _____

What helps the pain go away: _____

Does having your condition ever make you: ANGRY: ☐ No ☐ Yes SAD: ☐ No ☐ Yes

What do you think it will take to make you healthy:

Is there any other information that you think may be helpful in developing a program with you:

ON A SEPARATE SHEET OF PAPER, PLEASE TELL US A STORY ABOUT YOURSELF. PLEASE INCLUDE YOUR LIKES AND DISLIKES, YOUR CRAVINGS AND DISTASTES. INCLUDE WHAT TYPE OF WEATHER AND SEASON THAT YOU PREFER. ALSO INCLUDE ANYTHING THAT YOU THINK MAY BE PECULIAR TO YOU. MOST IMPORTANT, PLEASE INDICATE TO US WHAT YOU THINK IS THE CAUSE OF YOUR PROBLEM. FOR THIS SECTION WE DO NOT NEED ALL THE DETAILS, BUT AS MANY GENERALITIES THAT YOU CAN GIVE.

THANK YOU FOR ANSWERING THE QUESTIONS