Iowa Specialty Hospitals & Clinics
Specializing in You

403 1st Street SE
Belmond, Iowa 50421
(T) 641-444-3500 / 844-474-4321

1316 South Main Street
Clarion, Iowa 50525
(T) 515-532-2811 / 844-474-4321

IMPORTANT: PLEASE READ

Dear Patient:

In an effort to improve your experience with Carrie Reese ARNP and her team, we are requesting that you fill out the attached packet of information **in its entirety** and return it to our scheduling team. Once they receive your completed packet, they will call you to schedule your appointment with Carrie. Please note you will not receive a phone call until we have the required information found in the provided packet. The information is needed in advance so Carrie has an opportunity to review your information prior to your appointment. Having this step completed will help streamline the process for both you and Carrie. Once received, these documents will get loaded into your personal chart for Carrie to review. Please complete and return the attached documents ASAP with one of the four following methods:

1. You can upload the completed documents to your computer, save them, and attach the saved file to an email and send it to the following email address: packetreturns@iaspecialty.com

   -You can also do this from any portable device with email applications installed.

2. The second way to get the packet back to us is to fax it directly to our scheduling team with **Fax # 319-538-0434**

3. The Third method of return is you can walk the packet into any ISH location and have them fax it to the above-listed fax #: Those locations are Belmond, Fort Dodge, Webster City, Garner, Hampton, Rockwell, Ames, Des Moines Weight Loss, Clear Lake, and Boone. If you live in Clarion, you can hand deliver to the Specialty Clinic.

4. The Fourth method of return is by traditional mail. If you have opted for this method upon initial conversations with our scheduling team, please use the enclosed pre-labeled envelope. If you did not choose this method, there will be no envelope enclosed.

   If you change your mind on a free electronic submission and were not provided an envelope, you can still use the mail-in option. Simply place your completed packet in an appropriately sized envelope and return it to the following address:

Attn: Specialty Clinic Scheduling Team
Iowa Specialty Hospitals and Clinics
1316 South Main Street
Clarion, IA 50525

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KEEP THIS PAGE FOR YOUR APPOINTMENT RECORDS

Dear_____,

Your consultation is scheduled for_____at_____

In_____

Clarion Clinic	**Belmond Clinic**	**Garner Clinic**
1316 S Main St	**403 1st ST SE**	**840 W US-18**
Clarion, IA 50525	**Belmond, IA 50421**	**Garner, IA 50438**

Items to bring with you for your appointment with **Carrie Reese**

- Identification
- Up to date insurance information or cards

*****Please come 15 minutes early so that you can be registered prior to your appointment time*****

If you have any questions, please call Amy at (515)-532-9312, and thank you for choosing Iowa Specialty Hospitals and Clinics for your care needs

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New Patient GI Clinic Intake Form

Patient Name:_____ Date of Birth:_____

Date of appointment:_____

Onset of Symptoms:

Approximately when did the issue begin?

_____

_____

How did your current issue begin? ☐ Gradually ☐ Suddenly

Since your issue began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Have you been treated by another provider for the same issue?

Who?_____

Where?_____

When?_____

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Abdominal Surgery

☐ Gallbladder Removal When and where?_____

☐ Appendectomy When and where?_____

☐ Colon Resection When and where?_____

☐ Bariatric Surgery When and where?_____

☐ Hernia Repair When and where?_____

☐ Others When and where?

_____

☐ Colonoscopy When and where?_____

☐ EGD (upper endoscopy) When and where?_____

**** Please have records faxed to 319-538-0434 if not done at our facility****

Abdominal imaging:

Xray ☐ **Yes** ☐ **No** When?_____ Where?_____

CT ☐ **Yes** ☐ **No** When?_____ Where?_____

MRI ☐ **Yes** ☐ **No** When?_____ Where?_____

Swallow Studies ☐ **Yes** ☐ **No** When?_____Where?_____

Other forms of imaging _____

****Please have images sent and report faxed to 319-538-0434 if not at our facility****

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Abdominal Pain ☐ Yes ☐ No

Location:

Right Upper Abdomen ☐	Left Lower Abdomen ☐	Middle Upper Abdomen ☐
Right Lower Abdomen ☐	Left Upper Abdomen ☐	Middle Lower Abdomen ☐
Upper Abdomen ☐	Lower Abdomen ☐	Middle Abdomen ☐

Does the pain radiate? ☐ **Yes** ☐ **No** **If yes, where?**_____

Description of Pain: Circle All That Apply

Sharp ☐	Shooting ☐
Stabbing ☐	Cramping ☐
Aching ☐	Dull ☐
Burning ☐	

☐ **Constant** ☐ **Intermittent**

Is the pain worse at one point of the day versus another? ☐ **Yes** ☐ **No**

Indicate here: Morning ☐ Afternoon ☐ Evening ☐ Overnight ☐

What makes your pain worse?

_____

_____

What makes your pain better?

_____

_____

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Constipation? ☐ **Yes** ☐ **No** **If yes, how long?**_____

Have you taken or are you taking?

Miralax	☐**Yes**	☐**No**	For how long?_____	Effective?	☐**Yes**	☐**No**
Dulcolax	☐**Yes**	☐**No**	For how long?_____	Effective?	☐**Yes**	☐**No**
Senna	☐**Yes**	☐**No**	For how long?_____	Effective?	☐**Yes**	☐**No**
Milk of Magnesia	☐**Yes**	☐**No**	For how long?_____	Effective?	☐**Yes**	☐**No**
Mag Citrate	☐**Yes**	☐**No**	For how long?_____	Effective?	☐**Yes**	☐**No**
Suppositories	☐**Yes**	☐**No**		Effective?	☐**Yes**	☐**No**
Enemas	☐**Yes**	☐**No**		Effective?	☐**Yes**	☐**No**
Fiber	☐**Yes**	☐**No**		Effective?	☐**Yes**	☐**No**
Other Prescriptions	☐**Yes**	☐**No**		Effective?	☐**Yes**	☐**No**

Types: _____

Diarrhea ☐ N/A

For how long?_____

Have you taken or are you taking?

Imodium?	☐**Yes**	☐**No**	For how long?_____	Effective?	☐**Yes**	☐**No**
Pepto Bismol?	☐**Yes**	☐**No**	For how long?_____	Effective?	☐**Yes**	☐**No**
Any prescriptions?	☐**Yes**	☐**No**	For how long?_____	Effective?	☐**Yes**	☐**No**

Types: _____

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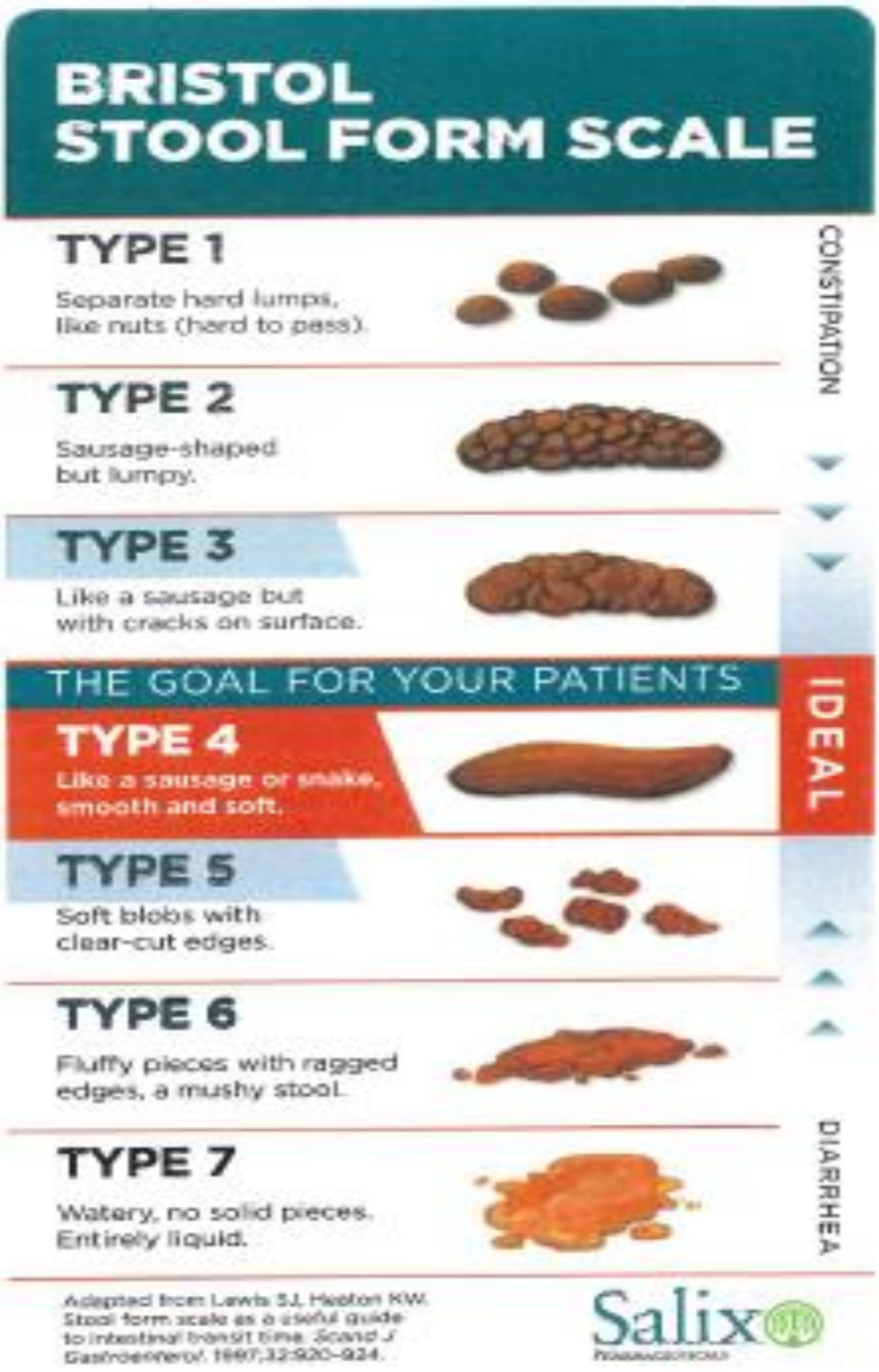

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Acid Reflux ☐ N/A

Have you taken or are you taking?

Omeprazole ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

Pantoprazole ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

Rabeprazole ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

Esomeprazole ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

Lansoprazole ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

Dexlansoprazole ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

TUMS ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

Pepcid ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

Other ☐ **Yes** ☐ **No**

Type:_____

_____

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Nausea/Vomiting ☐ N/A

How long? _____ **Constant** ☐ **Intermitent** ☐

What makes it worse/better?

_____

_____

Have you taken?

Ondansetron ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

Metoclopramide ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

Prochlorperazine ☐ **Yes** ☐ **No** For how long?_____ Effective? ☐ **Yes** ☐ **No**

Painful Swallowing? ☐ **Yes** ☐ **No** For how Long?_____

Difficulty Swallowing? ☐ **Yes** ☐ **No** For how Long?_____

Epigastric Pain? ☐ **Yes** ☐ **No** For how Long?_____

Coughing up blood? ☐ **Yes** ☐ **No** For how Long?_____

Dry nonproductive cough? ☐ **Yes** ☐ **No** For how long? _____

Appetite issues? ☐ **Yes** ☐ **No** For how long?_____

Weight loss? ☐ **Yes** ☐ **No** For how long?_____

If yes, how much weight has been lost?_____

Anemia? ☐ **Yes** ☐ **No** For how long?_____

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Bowel patterns:

How many times per day do your bowels move? _____

Consistency_____

Blood with bowel movements? ☐ **Yes** ☐ **No**

Dark or black stools? ☐ **Yes** ☐ **No**

Bloating? ☐ **Yes** ☐ **No**

Odor? ☐ **Yes** ☐ **No**

Increased Flatulence? ☐ **Yes** ☐ **No**

Fat in stool or greasy? ☐ **Yes** ☐ **No**

Have you completed any stool samples? ☐ **Yes** ☐ **No**

If yes, **when?**_____

Where?_____

Results?_____

Is there any other information you would like Carrie to know?

_____

_____

_____

_____

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Current Medications:

**Please indicate which (if any) of the following blood-thinners you are taking and what Doctor prescribed it?

_____

☐ Aggrenox ☐ Coumadin / Warfain ☐ Effient ☐ Lovenox ☐ Plavix ☐ Pletal ☐ Pradaxa

☐ Prasugrel ☐ Ticlid ☐ Other _____

Pharmacy Name: _____

Please list all medications you are currently taking. (Attach an additional sheet, if needed).

Medication Name	Dose	Frequency

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Are you currently taking any pain medication? **Yes** ☐ **No** ☐

If yes, list name of medications _____

Time of last dose _____ **Date of last dose** _____

Allergies:

Do you have any known drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to.

_____

_____

_____

Topical Allergies: ☐ Iodine ☐ Latex ☐ Tape Are you allergic to shellfish? ☐ Yes ☐ No

Family History:

**Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other medical problems:

_____

_____

☐ I HAVE **NO** SIGNIFICANT FAMILY MEDICAL HISTORY. ☐ I AM ADOPTED (No Medical History Available)

Social History:

Are you capable of becoming pregnant? ☐ Yes ☐ No *If so,* are you currently pregnant? ☐ Yes ☐ No

Highest level of education obtained: ☐ Grammar School ☐ High School ☐ College ☐ Post-graduate

Alcohol Use: ☐ Daily Limited Use ☐ History of Alcoholism ☐ Current Alcoholism

☐ Never Drinks Alcohol ☐ Drinks Alcohol Socially

Tobacco Use: ☐ Current Tobacco User ☐ Former Tobacco User ☐ Has Never Used Tobacco

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Illegal Drug Use: ☐ Denies Any Illegal Drug Use ☐ Currently Using Illegal Drugs (Which: _____)

☐ Currently uses Marijuana ☐ Currently Using Someone Else's Prescription Medications

☐ Formerly Used Illegal Drugs (not currently using) (Which :_____)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No (Which :_____)

Past Medical History:

**Mark the following conditions/disease that you have been treated for in the past:

GENERAL MEDICAL

☐ Pneumonia ☐ Kidney Infections(s) ☐ Cancer – Type _____

☐ Tuberculosis ☐ Kidney Stones ☐ Diabetes – Type_____

☐ Valley Fever ☐ Urinary Incontinence ☐ HIV / AIDS

HEAD/EYES/EARS/NOSE/THROAT

☐ Headaches
☐ Migraines
☐ Head Injury
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Glaucoma

CARDIOVASCULAR/HEMOATOLOGIC

☐ Anemia
☐ Bleeding Disorders
☐ Heart Attack
☐ High Cholesterol
☐ Mitral Valve Prolapse
☐ Murmur
☐ Phlebitis
☐ Poor Circulation
☐ Stroke
☐ Coronary Artery Disease

GASTROINTESTINAL

☐ Bowel Incontinence
☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding

HEPATIC

☐ Hepatitis A (active / inactive / unsure)
☐ Hepatitis B (active / inactive / unsure)
☐ Hepatitis C (active / inactive / unsure)

MUSCULOSKELETAL

☐ Amputation
☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Chronic Low Back Pain
☐ Chronic Neck Pain
☐ Fibromyalgia
☐ Joint Injury
☐ Osteoarthritis
☐ Osteoporosis
☐ Phantom Limb Pain
☐ Rheumatoid Arthritis
☐ Tennis Elbow
☐ Vertebral Compression Fracture

NEUROPSYCHOLOGICAL

☐ Alcohol Abuse
☐ Alzheimer's disease
☐ Bipolar Disease
☐ Depression
☐ Epilepsy
☐ Prescription Drug Abuse
☐ Multiple Sclerosis
☐ Paralysis
☐ Peripheral Neuropathy
☐ Schizophrenia
☐ Seizures
☐ Reflex Sympathetic Dystrophy/CRPS
☐ Other diagnosed Conditions

_____

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RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD

GENITOURINARY/NEPHROLOGY

- ☐ Bladder Infections
- ☐ Dialysis

Review of Systems:

***Mark the following conditions/disease that you have been treated for in the past:*

CONSTITUTIONAL

- ☐ Chills
- ☐ Difficulty Sleeping
- ☐ Easy Bruising
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Fatigue
- ☐ Fevers
- ☐ Insomnia
- ☐ Low Sex Drive
- ☐ Night Sweats
- ☐ Tremors
- ☐ Unexplained Weight Gain
- ☐ Unexplained Weight Lost
- ☐ Weakness

☐

EYES

- ☐ Recent Visual Changes

EARS/NOSE/THROAT/NECK

- ☐ Dental Problems
- ☐ Earaches
- ☐ Hearing Problems
- ☐ Nosebleeds
- ☐ Recurrent Sore Throat
- ☐ Ringing in the Ears
- ☐ Sinus Problems

CARDIOVASCULAR

- ☐ Bleeding Disorder
- ☐ Chest Pain
- ☐ Deep Vein Thrombosis
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Lightheadedness
- ☐ Shortness of Breath during sleep
- ☐ Swelling in the feet

RESPIRATORY

- ☐ Cough
- ☐ Wheezing
- ☐ Pulmonary Embolism
- ☐ Shortness of Breath on exertion/effort
- ☐ Shortness of breath on rest

☐

GASTROINTESTINAL

- ☐ Abdominal Cramps
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Coffee Ground Appearance in vomit
- ☐ Dark and Tarry Stools
- ☐ Hernia
- ☐ Vomiting

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MUSCULOSKELETAL

- [ ] Back Pain
- [ ] Joint Pain
- [ ] Joint Stiffness
- [ ] Joint Swelling
- [ ] Muscle Spasms
- [ ] Neck Pain

GENITOURINARY/NEPHROLOGY

- [ ] Blood in Urine
- [ ] Flank Pain
- [ ] Decrease Urine Flow/Frequency/Volume
- [ ] Painful Urination

NEUROLOGICAL

- [ ] Carpal Tunnel Syndrome
- [ ] Dizziness
- [ ] Headaches
- [ ] Numbness/Tingling
- [ ] Instability when walking
- [ ] Tremors
- [ ] Seizures

PYSCHIATRIC

- [ ] Depressed Mood
- [ ] Feeling Anxious
- [ ] Stress Problems
- [ ] Suicidal Thoughts
- [ ] Suicidal Planning

Medical History and Consent for Treatment:

I certify that the above information is accurate, complete and true.

I authorize Iowa Specialty Hospital and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Iowa Specialty Hospital to retrieve an review my medication history. I understand that this will become part of my medical record. By adding your name below you are confirming all the provided information is acurrage and true, and you agree that your typed name represents your legal signature.

Patient Signature: _____ Date: _____

Revised 07/22/2022

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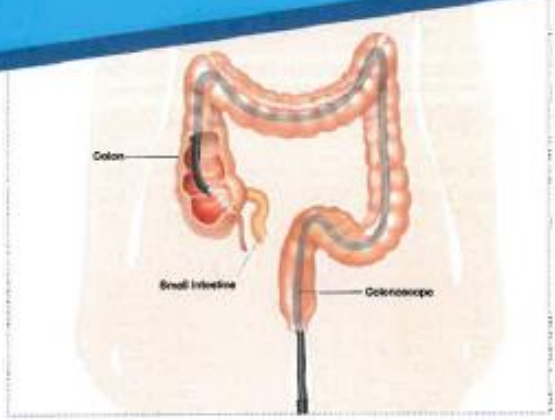
COLORECTAL CANCER: *You Can Prevent It*



PHYSICIANS FROM THE AMERICAN COLLEGE OF GASTROENTEROLOGY want you to know that screening Colonoscopy can find growths in the colon called polyps so they can be removed before they turn into Colorectal Cancer.

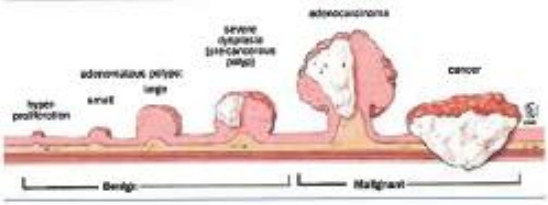


Figure 1. Progression from colorectal polyp to cancer. Not all polyps become cancer, but all cancer starts in a polyp. Image credit: Thirumurthy et al., BMJ, 2016

About COLON POLYPS

- A polyp is a small clump of cells on the lining of the colon. Most colon polyps are harmless. Some colon polyps can develop into colorectal cancer, often fatal when found in its later stages.
- Not all polyps turn into cancer, but all cancers start as polyps.
- Because colon polyps do not usually cause symptoms, it is important to have regular colorectal screenings such as colonoscopy.
- Remember: screening by colonoscopy with polyp removal prevents Colorectal Cancer before it can start.

45 IS THE NEW *50*

AGE 45 is now recommended as the time to start screening for colorectal cancer among all average risk adults according to the American College of Gastroenterology.

An Important CHANGE

- This is an important change from earlier guidelines that used to recommend starting at age 50 for most people and age 45 for African Americans only. Now "45 is the new 50" to start screening for everyone at average risk for colorectal cancer.

Never Ignore NEW OR WORRYING SYMPTOMS

- Reach out to your health care providers if regardless of your age you have any new or worrying symptoms such as blood in the stool, a change in bowel habits, rectal or abdominal pain, or unexpected weight loss, unexplained or new anemia.

Learn About Your Screening Options for Colorectal Cancer: **gi.org/coloncancer**

Find a gastroenterologist near you: **gi.org/find-a-gastroenterologist**

American College of Gastroenterology | gi.org
Follow ACG on Twitter @AmCollegeGastro