

PATIENT INFORMATION

NAME _____ DOB _____ PROCEDURE DATE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE# _____

REFERRING MD _____ REASON FOR VISIT _____

MEDICATION HISTORY

ALLERGIES _____ NONE LATEX allergy Y/N

PLEASE LIST ALL MEDICATIONS AND THEIR DOSAGES. INCLUDE REASON FOR USE. NONE

DO YOU TAKE?

NONE ASPIRIN BC POWDER ALEVE MOTRIN IBUPROFEN
 VITAMIN E COUMADIN PLAVIX LOVENOX TICLID/AGRENOX

MEDICAL HISTORY

HEIGHT _____ WEIGHT _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? NONE

- CARDIAC: HIGH BLOOD PRESSURE HIGH CHOLESTEROL HEART VALVE DISEASE ANGINA IRREG HEART BEAT
 STENT PACEMAKER HEART ATTACK HEART FAILURE OTHER
PULMONARY: ASTHMA EMPHYSEMA COPD SLEEP APNEA
GI: ACID REFLUX BARRETT'S ESOPHAGUS COLITIS/CROHN'S COLON POLYPS COLOSTOMY
 ULCERS DIVERTICULITIS COLON CANCER/POLYPS HEPATITIS PANCREATITIS
GU: BPH URINARY INCONTINENCE ABN MENSES URINARY TRACT INFECTIONS
RENAL / ENDO: DIABETES KIDNEY PROBLEMS DIALYSIS THYROID PROBLEMS
NEUROMUSC: STROKE /TIA PARKINSON'S MIGRAINES SEIZURES
PSYCHOLOGIC: DEPRESSION ANXIETY BIPOLAR DISORDER SCHIZOPHRENIA
AUTOIM/MISC: ANEMIA LUPUS HIV/AIDS RHEUMATOID DISORDER
CANCER: GI OTHER (Please List) _____ CHEMO Y/N RADIATION Y/N

OTHER ILLNESSES: _____

DO YOU TAKE ANTIBIOTICS PRIOR TO DENTAL / MEDICAL PROCEDURES? Y/N

ARE YOU CURRENTLY PREGNANT? _____ ARE YOU CURRENTLY BREASTFEEDING? _____

FAMILY HISTORY

NONE INDICATE WHICH FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING

- ESOPHAGEAL CANCER _____ LUNG DISEASE _____ OTHER _____
 STOMACH CANCER _____ HEART DISEASE _____ LIVER DISEASE _____
 COLON CANCER _____ GYN CANCER _____ IBD _____
 DIABETES _____ PANCREATIC CANCER _____ CELIAC DISEASE _____

SURGICAL /ENDOSCOPY HISTORY

HAVE YOU EVERY HAD A PROBLEM WITH ANESTHESIA? Y/N

- NONE COLONOSCOPY UPPER ENDOSCOPY CARDIAC SURGERY HEART STENT
 COLON SURGERY GALLBLADDER APPENDECTOMY OBESITY SURGERY VALVE REPLACEMENT
 HYSTERECTOMY JOINT SURGERY VASCULAR SURGERY BREAST BIOPSY /SURGERY OTHER _____

SOCIAL HISTORY

PLEASE INDICATE ALL THAT APPLY TO YOU

- STATUS SINGLE MARRIED DIVORCED WIDOWED
TOBACCO USE NEVER FORMER ACTIVE 1 2 3 PACKS / DAY
ALCOHOL USE NEVER FORMER ACTIVE 2 7 14 DRINKS / WEEK

OCCUPATION _____

DIGESTIVE HEALTHCARE

PATIENT DEMOGRAPHICS

Today's Date: _____ Birthdate: _____ SS#: _____
Patient Name: _____ Sex: _____
Address: _____
Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____
Email Address: _____ Can we leave your medical information on your voice mail? _____
Emergency Contact: _____ Phone #: () _____ Relationship: _____
Primary Insurance: _____ ID#: _____
Policy Holder: _____ Relationship to Policy Holder: _____
Secondary Insurance: _____ ID #: _____
Policy Holder: _____ Relationship to Policy Holder: _____
Employer: _____
Primary Care Physician: _____

I authorize the physician in charge to administer medical care as is necessary. Digestive Healthcare, PA's policy of payment has been explained to me, and I agree to be responsible for all medical expenses incurred as a result of services provided by Digestive Healthcare, PA. Copayments are due at the time of service. My payment options are cash, check, or charge.

I understand that Digestive Healthcare, PA will file all insurance claims on my behalf. I agree that I am ultimately responsible for all charges incurred at Digestive Healthcare, PA regardless of third party liability. I also authorize Digestive Healthcare, PA to release any information necessary to file my claim.

I authorize the release of any medical information in possession of Digestive Healthcare, PA to any consultants or medical personnel for the purpose of rendering treatment to myself or to continue my care.

I have been made aware of the Notice of Privacy Practices and Cancellation Policy for Digestive Healthcare, PA and have received a copy if requested.

Patient Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

DIGESTIVE HEALTHCARE

REVIEW OF SYSTEMS

PLEASE CHECK YES OR NO FOR EACH SELECTION BELOW

		Yes/No			Yes/No			Yes/No
CONSTITUTIONAL:			WEIGHT LOSS			FEVER		FATIGUE
EYES:			GLAUCOMA			VISION PROBLEM		EYE PAIN
ENT:			RUNNY NOSE			SINUS PRESSURE		MOUTH SORES
HEART:			TOOTH DISEASE			SORE THROAT		HOARSENESS
			CHEST PAIN			HEART RACING		ANKLE SWELLING
LUNGS:			LEG PAIN WALKING			DIZZINESS		FAINING SPELLS
			SHORTNESS OF BREATH			COUGH		WHEEZING
ENDOCRINE:			INCREASED THIRST			INCREASED URINATION		LOSS OF HAIR
GI:			HEARTBURN			TROUBLE SWALLOWING		LOSS OF APPETITE
SKIN:			NAUSEA/VOMITING			DIARRHEA		CHANGE BOWEL HABIT
			CONSTIPATION			BLACK STOOLS		BLOOD IN STOOL
			JAUNDICE			ABDOMINAL PAIN		EARLY SATIETY
			RASH			PSORIASIS		SORES
MUSC/SKELETAL:			TROUBLE WALKING			TROUBLE STANDING		MUSCLE PAINS
IMMUNE:			ALLERGIES			FREQUENT INFECTIONS		SWOLLEN GLANDS
NEUROLOGIC:			MEMORY PROBLEMS			TEMPORARY BLINDNESS		SPEAKING PROBLEMS
HEMATOLOGIC:			HEADACHES			NUMBNESS / TINGLING		LOSS OF BALANCE
			NOSE BLEEDS			EASY BRUISING		BLOOD DONATION
GENITOURINARY:			PAIN WITH URINATION			PROBLEM STARTING URINATION		BLOOD IN URINE
PYSCHIATRIC:			DEPRESSED/ANXIOUS			SUICIDAL THOUGHTS		HEARING VOICES

PATIENT SIGNATURE / DATE: _____

PHYSICIAN SIGNATURE / DATE: _____