ADVANCED DIGESTIVE CARE
GASTROENTEROLOGY & HEPATOLOGY ASSOCIATES P.C.

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Patient Interview Form

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____ Today's Date: _____

Allergies/REACTIONS for example *rash, hives, vomiting*: ☐NO known allergies ☐NO known drug allergies
☐Sulfa (Sulfonamide Antibiotics) _____ ☐Penicillin_____ ☐Erythromycin_____
☐Iv Dye, Iodine Containing _____ ☐Latex gloves_____ ☐Eggs _____ ☐Adhesive Tape _____
☐Other: _____

Medications/DOSE and FREQUENCY for example Nexium 40mg *one capsule every morning*:

Past surgeries (Include dates if available):

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology :
☐Colon polyp ☐Colon cancer ☐Irritable Bowel Syndrome ☐Diverticulitis
☐Crohn's Disease ☐Ulcer Disease ☐Gastroesophageal Reflux Disease (GERD)
☐Diverticulitis ☐Ulcer Disease ☐Barrett's Esophagus ☐Bowel Obstruction
☐Hepatitis B ☐Hepatitis C ☐Fatty Liver ☐Anemia
☐Cirrhosis ☐Celiac Disease ☐Pancreatitis ☐Other: _____

Cardiology:
☐Coronary Artery Disease ☐Congestive Heart Failure ☐Heart Attack ☐High blood pressure
☐Atrial Fibrillation ☐Vascular Disease ☐Stroke ☐High Cholesterol
☐Transient Ischemic Attack ☐Valvular Heart Disease ☐Pacemaker ☐Coronary Artery Stents
☐Other: _____

Pulmonology: ☐C.O.P.D. ☐Asthma ☐Sleep Apnea ☐Wheezing ☐Other: _____

Other:
☐Anxiety Disorder ☐Depression ☐Bipolar Disorder ☐Arthritis ☐Breast Cancer
☐Current Pregnancy ☐Ovarian Cancer ☐Prostate Cancer ☐Skin Cancer ☐Lung Cancer
☐HIV Exposure ☐HIV Infection ☐Hypothyroidism ☐Kidney Disease ☐Seizures
☐Diabetes Mellitus, Insulin Dependent (Type 1) ☐Diabetes Mellitus, Non-Insulin Dependent (Type 2) ☐Other: _____

Patient Name: _____ Date of Birth: _____

Social History

Occupation: _____ ☐Full-time ☐Part-time ☐Student ☐Retired ☐Unemployed

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Alcohol: ☐None ☐Occasionally ☐Daily

Tobacco
Smoking Status: ☐Current every day smoker ☐Current some day smoker ☐Former smoker ☐Never smoker
☐Smoker, current status unknown ☐Light tobacco smoker ☐Heavy tobacco smoker ☐Unknown if ever smoked

Type: ☐Cigarettes Started: _____ Quit: _____ Quantity: _____ Frequency: _____
☐Cigars Started: _____ Quit: _____ Quantity: _____ Frequency: _____

Drug Use: ☐None
Type: ☐IV or Intranasal drugs Quantity: _____ Number: _____ Frequency: _____
☐Recreational Quantity: _____ Number: _____ Frequency: _____

Exercise: ☐None ☐Occasionally ☐Daily

Caffeine: ☐None ☐Occasionally ☐Daily

Family Medical History

☐ No knowledge of family history

Family History of/*whom* (*father, mother, etc*):

☐Celiac sprue _____ ☐Liver disease _____
☐Colon cancer_____ ☐Stomach cancer _____
☐Colon polyp _____ ☐Ulcerative Colitis/IBS _____
☐Crohn's disease _____ ☐Esophageal cancer _____
☐Other: _____

Review of Systems

Cardiovascular: ☐None
☐Chest Pain
☐Dyspnea with exercise
☐Irregular heart beat
☐Palpitations
☐Peripheral edema

Neurological: ☐None
☐Dizziness ☐Seizures
☐Fainting ☐Tremors
☐Frequent headaches ☐Vertigo
☐Migraine ☐Memory loss
☐Numbness or tingling

Gastrointestinal: ☐None
☐Abdominal pain ☐Heartburn
☐Abdominal swelling ☐Nausea
☐Change in bowel habits ☐Rectal bleeding
☐Constipation ☐Stomach cramps
☐Diarrhea ☐Vomiting
☐Gas ☐Difficulty swallowing

Respiratory: ☐None
☐Asthma
☐Cough
☐Dyspnea
☐Excessive sputum
☐Coughing up blood
☐Shortness of breath with exercise
☐Wheezing

Consent to Import Medication History I consent to obtaining a history of my medications purchased at pharmacies. ☐Yes ☐No

Consent to Share Data I consent to having my medical/demographic info shared with other health care entities. ☐Yes ☐No

Reminder Preference I would like to receive preventive care and follow up care reminders. ☐Yes ☐No

Patient Signature _____ **Date** _____

Gastroenterology & Hepatology Associates – a division of Advanced Digestive Care
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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I,(name)_____, hereby authorize Gastroenterology & Hepatology Associates, P.C./Advanced Digestive Care, LLC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC can refuse to treat me.

I have been informed that Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC in writing, but if I revoke my consent, such revocation will not affect any actions that Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC took before receiving my revocation.

I understand that Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC has reserved the right to change the privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC does not have to agree to such restrictions, but that once such restrictions are agreed to, Gastroenterology & Hepatology Associates, P./ Advanced Digestive Care, LLC must adhere to such restrictions.

I have been informed that if I cancel any office visits with less than 24 hours notice, there is a $50 fee. If I cancel any facility procedures with less than 42 hours notice, there is a $200 fee. Disability forms that need to be completed by a practitioner, incur a $50 fee. FMLA forms that need to be completed by a practitioner incur a $25 fee.

I authorize Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC to share confidential information with the following individual(s).

Name/Ph #:_____ Relationship: _____ ☐*Emergency contact* ***ONLY***

Name/Ph #:_____ Relationship: _____ ☐*Emergency contact* ***ONLY***

I authorize Gastroenterology & Hepatology Associates, P.C./ Advanced Digestive Care, LLC to leave confidential medical information on the following answering machine number(s).

☐ Home # _____ ☐ Work # _____

☐ Cell # _____ CHECK the following box if NO text messages may be sent ☐ NO text alerts

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____ _____
Printed name of patient/patient's representative **Relationship to the patient**