

Digestive HealthCare Center, P.A.

(908) 218-9222 Fax (908) 218-9818

Medical and Family History Form

Please fill in the squares for the appropriate health information

Name: _____

Today's Date: _____

Chart No.: _____

Date of Birth: _____

Reason for Visit: _____

Allergies

None Codeine Erythromycin IV Contrast Morphine Penicillin Sulfa Versed

Aspirin Demerol Iodine Latex Novocain Propofol Tape

Other _____

Past or Present Medical Illnesses

None Crohn's Disease Hepatitis B Migraines Sleep Apnea

Anemia Depression Hepatitis C Osteoarthritis Stomach Ulcer

Asthma Diabetes High Blood Pressure Pancreatitis Stroke

Atrial Fibrillation Diverticulitis High Cholesterol Paralysis TB (Tuberculosis)

Breast Cancer Diverticulosis High Triglycerides Parkinson's Disease TB Skin Test Positive

Cancer Duodenal Ulcer HIV/AIDS Pneumonia Thyroid Disease

Chronic Lung Disease (COPD) Fatty Liver Irregular Heart Beat Problems with anesthesia Ulcerative Colitis

Cirrhosis of Liver Frequent Urinary Tract Infections Irritable Bowel Syndrome Reflux Uterine Cancer

Colitis Gallstones Kidney Disease Rheumatic Fever

Colon Cancer Heart Attack - MI Kidney Failure Rheumatoid Arthritis

Colon Polyps Heart Murmur Kidney Stone Seizures

Congestive Heart Failure Hepatitis A Lactose Intolerance Skin Cancer

Other _____

Previous Surgeries/Hospitalizations/Procedures:

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Liver | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Breast | <input type="checkbox"/> EGD/Upper Endoscopy | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Obesity Surgery | <input type="checkbox"/> Transplant Surgery |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> ERCP | <input type="checkbox"/> Hysterectomy Partial | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Cardiac Surgery | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hysterectomy Total | <input type="checkbox"/> Prostate | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Colon Resection - Left | <input type="checkbox"/> Heart Bypass Surgery | <input type="checkbox"/> Joint Surgery/ Replacement | <input type="checkbox"/> Sigmoidoscopy | |
| <input type="checkbox"/> Colon Resection – Right | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Kidney | <input type="checkbox"/> Stomach | |
| <input type="checkbox"/> Other _____ | | | | |

Social History – Alcohol:

- | | | | |
|--------------------------------|--|---------------------------------|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> More than 2 days/week | <input type="checkbox"/> Rarely | <input type="checkbox"/> Less than 2 days/week |
| <input type="checkbox"/> Daily | <input type="checkbox"/> I quit using alcohol | | |

Social History – Tobacco:

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> I use tobacco products | <input type="checkbox"/> I quit using tobacco products | <input type="checkbox"/> I have never used tobacco products | | |
| <input type="checkbox"/> Cigarettes: | <input type="checkbox"/> 1 pack per day | <input type="checkbox"/> 1 ½ pack per day | <input type="checkbox"/> 2 packs per day | <input type="checkbox"/> Greater than 2 packs per day |
| <input type="checkbox"/> Cigars | <input type="checkbox"/> Smokeless tobacco | | | |

Social History Illicit Drug Use:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> I use illicit drugs | <input type="checkbox"/> I quit using illicit drugs | <input type="checkbox"/> I have never used illicit drugs | <input type="checkbox"/> Injection drug use |
|--|---|--|---|

Social History Occupation:

Patient Occupation _____ Veteran

Review of Systems (Current Symptoms)

Gastrointestinal:

- None Bloating Flatulence/gas Rectal bleeding Weight gain
- Abdominal Pain Change in Bowel Habits Heartburn Rectal urgency Weight loss
- Anal/rectal Pain Constipation Mucus in stool Reflux
- Belching Diarrhea Nausea Soiling stool/incontinence
- Black stools Difficulty swallowing Pain with bowel movement Vomiting
- Other _____

Urinary:

- None Pain with urination
- Blood in urine Change in urinary frequency
- Kidney stones Other _____

Skin:

- None Skin Rash
- Itching Suspicious lesions
- Jaundice Other _____

Cardiovascular:

- None Heart murmur as an adult Shortness of breath when lying flat Palpitations
- Chest pain with exertion/angina Shortness of breath with exertion
- Other _____

Neurological:

- None Numbness in extremities
- Dizziness Seizures
- Fainting spells Stroke/weakness
- Frequent headaches Tremors
- Memory Disturbance Other _____

Endocrine:

- None Heat intolerance
- Hair change/loss Other _____

Constitutional:

- None Loss of appetite
- Chills Night sweats
- Fever Other _____

Psychiatric:

- None Depression
- Anxiety/panic Other _____

Digestive HealthCare Center, PA
511 Courtyard Drive, Building 500, Hillsborough, NJ 08844
(908) 218-9222 Fax (908) 218-9818

Patient Information

*In order for us to file your insurance, the following form must be completed.

PATIENT'S PERSONAL INFORMATION			Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other		
Name: _____			_____		
Last Name		First Name		Initial	
Birthdate: _____			SS#: _____		
			Male: ___ Female: ___		
Street Address: _____ (Apt.# _____) City: _____					
State: _____ Zip: _____ Home Phone: (____) _____					
Cell # (____) _____ Work Phone: (____) _____					
Email Address: _____					
Employer's Name & Address: _____					
Employer's Phone: (____) _____ Your Occupation: _____					
Spouse's Name: _____					
Last Name		First Name		Initial	
Spouse Birthdate: _____			Spouse SS#: _____		
PATIENT'S INSURANCE INFORMATION			SELF PAY (No insurance) <input type="checkbox"/>		
Primary Insurance Company Name: _____					
Policyholder Name: _____			Policyholder Birthdate: _____		
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other ID#: _____ Group #: _____					
Secondary Insurance Company Name: _____					
Policyholder Name: _____			Policyholder Birthdate: _____		
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other ID#: _____ Group #: _____					
PATIENT'S REFERRAL INFORMATION			Primary Care Dr./Referring Doctor: _____		
Address: _____			Phone: (____) _____		
Pharmacy Name: _____			Pharmacy Phone: (____) _____		
Pharmacy Address: _____					
EMERGENCY CONTACT					
Name of person NOT living with you: _____			Relationship: _____		
Street Address: _____ (Apt. # _____) City: _____					
State _____			Zip Code _____		
Home Phone: (____) _____			Work or Cell # (____) _____		

Should inaccurate or omitted insurance information be supplied causing a reduction or non-payment of benefits, the obligation of payment will be transferred to the responsible party. I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Digestive HealthCare Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature: _____ Date: _____

Digestive HealthCare Center, P.A.

RELEASE OF INFORMATION FORM

Dear Patient,

This form is required to release any of your medical information to your spouse, family, friends, physicians, attorneys, etc. Please complete at least one person or specify none. Please note: if you state "None", we CANNOT release ANY information to anyone.

I hereby give permission for representatives of Digestive HealthCare Center, P.A. to release or discuss y Protected Health Information (PHI) with the following individual(s):

Relatives: Name _____ Date of Birth _____
 Name _____ Date of Birth _____
 Name _____ Date of Birth _____
 Name _____ Date of Birth _____

Physicians: Name _____
 Name _____
 Name _____

Other: Name _____ Date of Birth _____
 Name _____ Date of Birth _____

COMMUNICATIONS:

Please indicate how you wish us to reach you:

1st Phone # Preference: _____ OK to leave a detailed message? _____

2nd Phone # Preference: _____ OK to leave a detailed message? _____

This release of information form will be in effect until notified of the contrary. If you want this form to expire on a particular date, indicate here. Date of Expiration: _____

PLEASE SIGN HERE:

Printed Name: _____ Date of Birth: _____

SIGNATURE: _____ Date: _____

Revised 3/25/09