

**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**

- |  |   |  |  |   |
|--|---|--|--|---|
| <input type="checkbox"/> None                              | <input type="checkbox"/> Crohn's Disease                      | <input type="checkbox"/> Hepatitis B                 | <input type="checkbox"/> Migraines                   | <input type="checkbox"/> Sleep Apnea              |
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Depression                           | <input type="checkbox"/> Hepatitis C                 | <input type="checkbox"/> Osteoarthritis              | <input type="checkbox"/> Stomach Ulcer            |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Pancreatitis                | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Atrial<br>Fibrillation            | <input type="checkbox"/> Diverticulitis                       | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Paralysis                   | <input type="checkbox"/> TB (Tuberculosis)        |
| <input type="checkbox"/> Breast Cancer                     | <input type="checkbox"/> Diverticulosis                       | <input type="checkbox"/> High Triglycerides          | <input type="checkbox"/> Parkinson's<br>Disease      | <input type="checkbox"/> TB Skin Test<br>Positive |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Duodenal Ulcer                       | <input type="checkbox"/> HIV/AIDS                    | <input type="checkbox"/> Pneumonia                   | <input type="checkbox"/> Thyroid Disease          |
| <input type="checkbox"/> Chronic Lung<br>Disease<br>(COPD) | <input type="checkbox"/> Fatty Liver                          | <input type="checkbox"/> Irregular Heart Beat        | <input type="checkbox"/> Problems with<br>anesthesia | <input type="checkbox"/> Ulcerative Colitis       |
| <input type="checkbox"/> Cirrhosis of<br>Liver             | <input type="checkbox"/> Frequent Urinary<br>Tract Infections | <input type="checkbox"/> Irritable Bowel<br>Syndrome | <input type="checkbox"/> Reflux                      | <input type="checkbox"/> Uterine Cancer           |
| <input type="checkbox"/> Colitis                           | <input type="checkbox"/> Gallstones                           | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Rheumatic Fever             |   |
| <input type="checkbox"/> Colon Cancer                      | <input type="checkbox"/> Heart Attack - MI                    | <input type="checkbox"/> Kidney Failure              | <input type="checkbox"/> Rheumatoid Arthritis        |   |
| <input type="checkbox"/> Colon Polyps                      | <input type="checkbox"/> Heart Murmur                         | <input type="checkbox"/> Kidney Stone                | <input type="checkbox"/> Seizures                    |   |
| <input type="checkbox"/> Congestive<br>Heart<br>Failure    | <input type="checkbox"/> Hepatitis A                          | <input type="checkbox"/> Lactose Intolerance         | <input type="checkbox"/> Skin Cancer                 |   |
| <input type="checkbox"/> Other _____                       |   |  |  |   |

**Previous Surgeries/Hospitalizations/Procedures:**

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

**Social History – Alcohol:**

- Never
- More than 2 days/week
- Rarely
- Less than 2 days/week
- Daily
- I quit using alcohol

**Social History – Tobacco:**

- I use tobacco products
- I quit using tobacco products
- I have never used tobacco products
- Cigarettes:  1 pack per day  1 ½ pack per day  2 packs per day  Greater than 2 packs per day
- Cigars
- Smokeless tobacco

**Social History Illicit Drug Use:**

- I use illicit drugs
- I quit using illicit drugs
- I have never used illicit drugs
- 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.

<b>PATIENT'S PERSONAL INFORMATION</b>			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#: _____		
<b>PATIENT'S INSURANCE INFORMATION</b>			<b>SELF PAY (No insurance) <input type="checkbox"/></b>		
<b>Primary</b> Insurance Company Name: _____					
Policyholder Name: _____			Policyholder Birthdate: _____		
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other ID#: _____ Group #: _____					
<b>Secondary</b> Insurance Company Name: _____					
Policyholder Name: _____			Policyholder Birthdate: _____		
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other ID#: _____ Group #: _____					
<b>PATIENT'S REFERRAL INFORMATION</b>			Primary Care Dr./Referring Doctor: _____		
Address: _____			Phone: (____) _____		
Pharmacy Name: _____			Pharmacy Phone: (____) _____		
Pharmacy Address: _____					
<b>EMERGENCY CONTACT</b>					
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:

1<sup>st</sup> Phone # Preference: \_\_\_\_\_ OK to leave a detailed message? \_\_\_\_\_

2<sup>nd</sup> 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