

DIGESTIVE DISEASE CLINIC

2400 Miccosukee Road • Tallahassee, FL 32308 • (850) 877-2105

Office Use
Account # \_\_\_\_\_

PATIENT REGISTRATION

PATIENT INFORMATION (PLEASE PRINT)

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
Full Name: \_\_\_\_\_
(AS LISTED ON INSURANCE CARD)

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Work Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Other Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Gender:  Male  Female Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
Month Day Year

Email: \_\_\_\_\_

Referring MD: \_\_\_\_\_

Primary MD: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated

EMPLOYMENT INFORMATION

Full-time  Part-time  Unemployed  Self  Retired  Military  Student

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Preferred Pharmacy \_\_\_\_\_

INFORMATION RELEASE:

Emergency Contact Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_

Do you want your treatment at Digestive Disease Clinic discussed with this person?  Yes  No  Home  Work  Other

The physicians and staff of the Digestive Disease Clinic consider all patient information confidential. Please list all individuals with whom we may discuss your medical condition, test results, and/or treatment plan.

YOU MAY DISCUSS MY TREATMENT AT THE DIGESTIVE DISEASE CLINIC WITH:

- 1. \_\_\_\_\_ Relationship \_\_\_\_\_ 3. \_\_\_\_\_ Relationship \_\_\_\_\_
2. \_\_\_\_\_ Relationship \_\_\_\_\_ 4. \_\_\_\_\_ Relationship \_\_\_\_\_

YOUR SIGNATURE BELOW ACKNOWLEDGES THE FOLLOWING:

- 1. I understand that I am responsible to pay for any health insurance deductibles; coinsurance or any charges incurred which are not covered by my insurance or third party payers. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Digestive Disease Clinic has provided me with a copy of the Notice of Privacy Practices as required by HIPAA.
2. This document serves as authorization for the release of my medical records to Digestive Disease Clinic from other physician offices and/or hospitals as necessary for my healthcare and to complete a related medical claim, as well as authorization for the release of my medical records from Digestive Disease Clinic to other physician offices and/or hospitals as necessary for my healthcare and to complete related medical claim. This information may include psychiatric, drug and/or alcohol abuse treatment and AIDS or HIV testing and treatment. This exchange of information will occur through the most secure and efficient method available, including but not limited to the community health information exchange utilizing the Big Bend Regional Healthcare Information Organization (BBRHIO) and/or the Florida Health Information Network (FHIN).

Signed: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Marking Instructions**

- Mark all items that apply to you
- Fill in the complete oval as shown ...



Please complete this history form. This will allow us to serve your health needs. The information contained herein is strictly confidential and will not be released unless you authorize us to do so.

PLEASE PRINT PATIENT'S LAST NAME

Form for patient's last name with 20 empty boxes.

PLEASE PRINT PATIENT'S FIRST NAME

Form for patient's first name with 15 empty boxes.

PATIENT'S DATE OF BIRTH

Form for patient's date of birth with boxes for Month, Day, and Year.

**PATIENT MEDICAL HISTORY** Fill in the oval if **YOU** have had any of the conditions listed below, or fill in the "NONE" oval.

**Gastrointestinal Conditions**

- Celiac Disease or Sprue
- Gastrointestinal Bleeding
- Irritable Bowel Syndrome
- Yellow Skin and/or Jaundice
- Stomach Ulcer or Duodenal Ulcer
- Esophageal Stricture or Narrowing
- History of Helicobacter Pylori (H. Pylori)
- Intestinal Infection
- Bowel Obstruction
- Acid Reflux/GERD
- Liver Failure/Cirrhosis
- Barrett's Esophagus
- Chronic Constipation
- Gallbladder Problems
- Anal Fissure
- Colon Polyps
- Diverticulitis
- Diverticulosis
- Crohn's Disease
- Ulcerative Colitis
- Alcohol Abuse
- Pancreatitis
- Hemorrhoids
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Other
- NONE**

**Non-Gastrointestinal Conditions**

- Congestive Heart Failure
- Hardening of the Arteries
- Heart Disease/Heart Attack
- Treatment with Blood Thinner
- Abnormal Heartbeat/Palpitations
- Antibiotic Treatment in Past 2 Months
- Exposure to HIV
- Seizure Disorder
- Multiple Sclerosis
- Bleeding Disorder
- High Blood Pressure
- Emphysema or COPD
- Asthma
- Diabetes
- Blood Clots
- HIV Positive
- Fibromyalgia
- Thyroid Disease
- Lupus
- Stroke
- Anemia
- NONE**

**Cancer**

- Esophagus
- Mouth/Throat
- Colon or Rectum
- Blood (e.g. Leukemia)
- Ovaries
- Stomach
- Prostate
- Pancreas
- Skin
- Lungs
- Uterus
- Breast
- Liver
- Other
- NONE**

**FAMILY HISTORY**

Family History Unknown  Adopted

Have any of your blood relatives had **Colorectal Cancer**?

	Yes	No	Age relative developed condition, if known						
			20's	30's	40's	50's	60's	70's	80+
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Son	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Have any of your blood relatives had **Colon Polyps**?

	Yes	No	Age relative developed condition, if known						
			20's	30's	40's	50's	60's	70's	80+
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Daughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Son	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Other family history:** Fill in the oval if a relative – parent, grandparent, sibling, children, aunt or uncle – has had one of the following.

- Mental Illness
- Prostate Cancer
- Stomach Cancer
- Bleeding Disorder
- Hemachromatosis
- Autoimmune Hepatitis
- Irritable Bowel Syndrome
- Cirrhosis
- Celiac Disease
- Breast Cancer
- Alcohol Abuse
- Uterine Cancer
- Ovarian Cancer
- Crohn's Disease
- Ulcerative Colitis
- Cancer, Other
- Blood Clots
- Pancreatitis
- Liver Failure
- Liver Cancer
- Heart Attack
- Hypertension
- Ulcer Disease
- Tuberculosis (TB)
- Stroke
- Diabetes
- Sickle Cell
- Gallstones
- Hepatitis B
- Hepatitis C
- Other
- NONE**

<b>Current Symptoms</b>		Mark all that apply – mark “NONE” if none apply within that section			
<b>General</b>	Lack of Appetite <input type="checkbox"/> Tiredness <input type="checkbox"/>	Night Sweats <input type="checkbox"/> Fever <input type="checkbox"/>	Unintentional Weight Loss (over 10 lbs) <input type="checkbox"/> <span style="float: right;">NONE <input type="checkbox"/></span>		
<b>Head, Ears, Eyes, Nose &amp; Throat</b>	Wear Glasses <input type="checkbox"/> Wear Contacts <input type="checkbox"/>	Glaucoma <input type="checkbox"/> Hoarseness <input type="checkbox"/>	Sleep Apnea <input type="checkbox"/> Decreased Hearing <input type="checkbox"/>	Headache <input type="checkbox"/> <span style="float: right;">NONE <input type="checkbox"/></span>	
<b>Cardiovascular</b>	Swelling of Hands or Feet <input type="checkbox"/> Fainting/Blacking Out <input type="checkbox"/>	Heart Valve Replacement <input type="checkbox"/> Elevated Blood Pressure <input type="checkbox"/>	Leg Cramps <input type="checkbox"/> Chest Pain <input type="checkbox"/>	Heart Stent <input type="checkbox"/> <span style="float: right;">NONE <input type="checkbox"/></span>	
<b>Genitourinary</b>	Kidney Disease <input type="checkbox"/> Blood in Urine <input type="checkbox"/>	Change in Urinary Stream <input type="checkbox"/> Painful Urination <input type="checkbox"/>	Pelvic Pain <input type="checkbox"/> Frequency <input type="checkbox"/>	<span style="float: right;">NONE <input type="checkbox"/></span>	
<b>Neurological</b>	Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/>	Loss of Consciousness <input type="checkbox"/> Weakness in Extremities <input type="checkbox"/>	Seizure <input type="checkbox"/> Stroke <input type="checkbox"/>	Difficult Speech <input type="checkbox"/> <span style="float: right;">NONE <input type="checkbox"/></span>	
<b>Endocrine</b>	Cold Intolerance <input type="checkbox"/> Excessive Thirst <input type="checkbox"/>	Heat Intolerance <input type="checkbox"/> Excessive Urination <input type="checkbox"/>	Thyroid Problem <input type="checkbox"/> <span style="float: right;">NONE <input type="checkbox"/></span>		
<b>Musculoskeletal</b>	Physical Disability <input type="checkbox"/>	Joint Stiffness <input type="checkbox"/>	Backache <input type="checkbox"/>	Arthritis <input type="checkbox"/>	<span style="float: right;">NONE <input type="checkbox"/></span>
<b>Skin</b>	Jaundice (yellow skin) <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> <span style="float: right;">NONE <input type="checkbox"/></span>				
<b>Respiratory</b>	Chronic Cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> <span style="float: right;">NONE <input type="checkbox"/></span>				
<b>Psychiatric</b>	Suicidal Thoughts <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> <span style="float: right;">NONE <input type="checkbox"/></span>				
<b>Blood</b>	Anemia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Easy Bruising <input type="checkbox"/> <span style="float: right;">NONE <input type="checkbox"/></span>				
<b>Breast</b>	Breast Mass <input type="checkbox"/> Breast Pain <input type="checkbox"/> <span style="float: right;">NONE <input type="checkbox"/></span>				

**Gastrointestinal – Mark any of these symptoms or conditions you CURRENTLY have.**

Hernia <input type="checkbox"/>	Abdominal Swelling <input type="checkbox"/>	Vomiting Blood <input type="checkbox"/>	Belching <input type="checkbox"/>
Nausea <input type="checkbox"/>	Food/Milk Intolerance <input type="checkbox"/>	Abdominal Pain <input type="checkbox"/>	Black Stool <input type="checkbox"/>
Diarrhea <input type="checkbox"/>	Get Full Quickly at Meals <input type="checkbox"/>	Painful Swallowing <input type="checkbox"/>	Laxative Use <input type="checkbox"/>
Bloating <input type="checkbox"/>	Jaundice/Yellow Skin Color <input type="checkbox"/>	Difficulty Swallowing <input type="checkbox"/>	Hemorrhoids <input type="checkbox"/>
Vomiting <input type="checkbox"/>	Pain with Bowel Movement <input type="checkbox"/>	Incontinence of Stool <input type="checkbox"/>	Blood in Stool <input type="checkbox"/>
Constipation <input type="checkbox"/>	Heartburn/Indigestion/Reflux <input type="checkbox"/>	Change in Bowel Habits <input type="checkbox"/>	Gas/Flatulence <input type="checkbox"/>
Colon Polyps <input type="checkbox"/>	Colitis <input type="checkbox"/>	Diverticulosis <input type="checkbox"/>	<b>NONE</b> <input type="checkbox"/>

**Has your stool tested positive for blood in the past 6 months?**      Yes       No

**Have you had any of these procedures?**

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Colonoscopy – Date: _____ Findings: _____
<input type="checkbox"/>	<input type="checkbox"/>	Flexible Sigmoidoscopy – Date: _____ Findings: _____
<input type="checkbox"/>	<input type="checkbox"/>	Upper Endoscopy – Date: _____ Findings: _____
<input type="checkbox"/>	<input type="checkbox"/>	ERCP (endoscopic retrograde cholangiopancreatography) Date: _____ Findings: _____
<input type="checkbox"/>	<input type="checkbox"/>	EUS (endoscopic ultrasound) Date: _____ Findings: _____
<input type="checkbox"/>	<input type="checkbox"/>	CT scan of abdomen or GI tract (past 6 months) Date: _____ Findings: _____
<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound of abdomen or GI tract (past 6 months) Date: _____ Findings: _____

**PERSONAL AND SOCIAL HISTORY**

Do you live alone?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you consume alcohol?	Never <input type="checkbox"/>	In the Past <input type="checkbox"/> Currently <input type="checkbox"/>
Average number of drinks per week (now or in past)?	7 or less <input type="checkbox"/>	8-14 <input type="checkbox"/> 15 or more <input type="checkbox"/>
How would you describe your cigarette smoking?	Never <input type="checkbox"/>	In the Past <input type="checkbox"/> Currently <input type="checkbox"/>
How many packs per day do you (or did you) smoke?	Less than 1 <input type="checkbox"/>	1-2 <input type="checkbox"/> More than 2 <input type="checkbox"/>
How many years have you (or did you) smoke?	5 or less <input type="checkbox"/>	6-10 <input type="checkbox"/> More than 10 <input type="checkbox"/>
Do you use other tobacco products?	Never <input type="checkbox"/>	In the Past <input type="checkbox"/> Currently <input type="checkbox"/>
How many caffeinated beverages do you consume per day?	None <input type="checkbox"/>	1-2 <input type="checkbox"/> 3-5 <input type="checkbox"/> more than 5 <input type="checkbox"/> occasional <input type="checkbox"/>
IV drug use or other recreational drug use?	Never <input type="checkbox"/>	In the Past <input type="checkbox"/> Currently <input type="checkbox"/>
Have you engaged in high risk behavior for sexually transmitted diseases (anal sex, homosexual activity, multiple sex partners)?	Never <input type="checkbox"/>	In the Past <input type="checkbox"/> Currently <input type="checkbox"/>
Have you ever had a Blood Transfusion?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you had any recent Foreign Travel?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have any Body Piercings?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have any Tattoos?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**SURGERIES** Please mark all surgeries you have had.

- |  |  |  |  |
|--|--|--|--|
| Cholecystectomy <input type="checkbox"/>                 | Liver Transplant <input type="checkbox"/>      | Shoulder Surgery <input type="checkbox"/>  | Back Surgery <input type="checkbox"/>  |
| Lysis of Adhesions <input type="checkbox"/>              | Hip Replacement <input type="checkbox"/>       | Weight Loss <input type="checkbox"/>       | Brain Surgery <input type="checkbox"/> |
| Pacemaker Placement <input type="checkbox"/>             | Gastric Resection <input type="checkbox"/>     | Hysterectomy <input type="checkbox"/>      | Stomach Ulcer <input type="checkbox"/> |
| Aortic Aneurysm Repair <input type="checkbox"/>          | Knee Replacement <input type="checkbox"/>      | Appendectomy <input type="checkbox"/>      | TURP <input type="checkbox"/>          |
| Coronary Artery Bypass Graft <input type="checkbox"/>    | Breast Augmentation <input type="checkbox"/>   | Colon Resection <input type="checkbox"/>   | Other <input type="checkbox"/>         |
| Automatic Cardiac Defibrillator <input type="checkbox"/> | Hiatus Hernia Surgery <input type="checkbox"/> | Kidney Transplant <input type="checkbox"/> | <b>NONE</b> <input type="checkbox"/>   |
| Heart Valve Replacement <input type="checkbox"/>         |  |  |  |

**ALLERGIES** Please mark any of these allergies you have.

- Contrast or Iodine Allergy
- Anaphylactic or other reaction to Anesthesia  Latex Rubber Allergy  No Known Medication Allergies

**Marital Status** Single  Married  Divorced  Widowed

**Ethnicity** Caucasian  African American  Asian   
Hispanic  American Indian  Other

**Language** English  Spanish  American Sign Language  Other

**What PRESCRIPTION medications are you taking at this time?** (Alternatively bring in an accurate list with you)

<u>Name of Medication</u>	<u>Dosage</u>	<u>Frequency</u>

**MEDICATION ALLERGIES**

Please list the medications or injections that have given you bad reactions. If possible, include your reactions (hives, welts, rash, itching, headaches, nausea, diarrhea, passed out, shock, shortness of breath).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OTHER PAST OPERATIONS OR MEDICAL PROBLEMS**

(Not noted above)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referring MD \_\_\_\_\_

Primary MD \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

**What OVER-THE-COUNTER medications are you taking?** (e.g. aspirin, Motrin, Tagament-HB, Vitamins, etc.)

<u>Name of Medication</u>	<u>Dosage</u>	<u>Frequency</u>