Essential Healthcare Group-Oregon Digestive
1755 Coburg Rd, Suite 301
Eugene, OR 97401-4900

Name: **DOB:**
Provider: **MRN:**
Visit Type: **DOS:**

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTH DATE	AGE

MAILING ADDRESS	CITY, STATE, ZIP	REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

HOME PHONE	DAY PHONE	CELL PHONE	EMAIL ADDRESS

HOW DO YOU PREFER TO BE CONTACTED?
Home Phone _____ Mobile Phone _____ (Voice _____ or Text_____) Day Phone _____ E-Mail_____

EMERGENCY CONTACT NAME/RELATIONSHIP	CONTACT PHONE	DATE OF SERVICE	GENDER	MARITAL STATUS

EMPLOYMENT INFORMATION

EMPLOYER:	TELEPHONE:	ADDRESS:	CITY, STATE, ZIP

RELATION TO PATIENT:	DATE OF INJURY:

RESPONSIBLE PARTY INFORMATION

NAME (Last, First Middle)	RELATIONSHIP TO PATIENT	BIRTH DATE	GENDER

LOCAL ADDRESS	CITY, STATE ZIP

HOME PHONE	DAY PHONE	CELL PHONE	EMAIL ADDRESS

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#

ADDRESS OF INSURANCE COMPANY	GROUP#

CITY, STATE ZIP	PHONE

NAME OF INSURED	RELATIONSHIP TO PATIENT	INSURED DOB	INSURED SSN#

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY	POLICY#

ADDRESS OF INSURANCE COMPANY	GROUP#

CITY, STATE ZIP	PHONE

NAME OF INSURED	RELATIONSHIP TO PATIENT	INSURED DOB	INSURED SSN#

DO YOU RESIDE IN A SKILLED NURSING FACILITY? YES _____ NO_____
DO YOU HAVE A LIVING WILL? YES _____ NO_____
WOULD YOU LIKE INFORMATION ON LIVING WILLS? YES _____ NO_____

Patient/Representative Signature: _____ Date :

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Patient Race and Ethnicity

As required by the State of Delaware, we are required to ask you the following questions:

Patient Race: (please circle the number that applies)

1. AMERICAN INDIAN OR ALASKAN NATIVE
   Definition: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

2. ASIAN
   Definition: A person having origins in any of the original peoples of the Far East, Southwest Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, and the Philippine Islands, Thailand, and Vietnam.

3 BLACK OR AFRICAN AMERICAN
   Definition: A person having origins in any of the black racial groups of Africa.

4. NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
   Definition: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

5. WHITE
   Definition: A person having origins in any of the peoples of Europe, North Africa, or the Middle East.

6. MULTIRACIAL
   Definition: A person having more than one or a combination of the above origins.

7. DECLINED
   Definition: A person who refuses to answer this question.

9. UNAVAILABLE
   Definition: A person who is unable to answer this question, or there is no available family member or caregiver to respond for the patient.

Patient Ethnicity: (Please circle the number that applies)

1. HISPANIC OR LATINO
   Definition: A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish decent regardless of race.

2. NOT HISPANIC OR LATINO
   Definition: A person not of Hispanic or Latino Ethnicity.

7. DECLINED
   Definition: A person who refuses to answer this question or cannot identify him/herself ethnicity.

9. UNAVAILABLE
   Definition: A person who is unable to answer this question, or there is no available family member or caregiver to respond for the patient.

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Multiple Disclosure and Consent Form

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I authorize Essential Healthcare Group physicians and staff to render medical treatment and evaluation needed. I further authorize order of diagnostic tests and treatment that may be necessary to diagnose and treat my illness or injuries. I hereby give my consent to EHG-Delaware to use or disclose, for carrying out treatment, payment or healthcare operations, and all protected health information contained in the patient record of:

(Patient Name)

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent any time by giving written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information. Written revocation of consent must be sent to the physician's office, Attn: Administration.

Signed: _____ **Date**

Printed Name:

RELEASE OF MEDICAL RECORDS

I authorize Essential Healthcare Group - Delaware, my admitting physician, or other physicians who render service to me, to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I hereby acknowledge that a copy of the Notice of Privacy Practices for the Essential Healthcare Group - Delaware has been made available to me. I have the right to obtain a paper copy upon request.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and I verify that all information reported to Essential Healthcare Group - Delaware is correct.

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

_____ _____
Signature of Patient or Responsible Person Printed Name

_____ _____
Relationship to Patient Date Signed

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Alternate Contact Information & Family/Friends Release of Information Authorization Form

Patient Name: _____ **Phone Number:** _____ (Home)

Patient Date of Birth: _____ **Phone Number:** _____(Other)

Email: _____

Part I Alternate Contact Information Authorization

Essential Healthcare Group has my Authorization to:

Y	**N**	leave medical information on my home/cell answering machine.
Y	**N**	contact me at my place of employment.
Y	**N**	leave medical information on voice mail at my place of employment.
Y	**N**	fax immunization records to schools and employers upon my verbal authorization.

Part II Family/Friends Release of Information Authorization

I authorize Essential Healthcare Group to discuss **ANY** information regarding my care with below -mentioned persons: (Only list names of persons you are authorizing us to discuss **ANY** information with.)

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Additional space is available on back of form if needed to include more Family/Friends

This Family/Friends Release of Information Authorization (Part II) is valid until Revoked in writing by the patient.

_____ **Date:**
Patient or Legal Representative Signature*

_____
Print Name/Relationship to Patient

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. The Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law. Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization.

*In the event this Authorization is signed by a legal representative other than parents of a minor child, documentation of legal authority must be attached. (i.e. Health Care Power of Attorney, or Court Appointed Health Care Representative.)
Alternate Contact Information & Family/Friends Release of Information Authorization Form

Consent to Receive Text Messages

I authorize Essential Healthcare Group (EHG) to contact me by SMS text message for health related notifications and/or appointment reminders. I understand that message/data rates may apply. I know that I am under no obligation to authorize EHG to send text messages. I may opt-out of receiving these communications at any time.

- ❑ Yes, sign me up for SMS text messages
- ❑ No thanks, I choose not to participate in SMS text messages

_____ **Date:**
Patient or Legal Representative Signature

_____
Print Name/Relationship to Patient

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NOTICE OF PRIVACY PRACTICES

ESSENTIAL HEALTHCARE GROUP - THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your health information is personal, and we are committed to protecting it. Your health information is also very important to our ability to provide you with quality care, and to comply with certain laws. This Notice applies to all records about care provided to you by Envision Healthcare's subsidiaries. (Your physician may have different policies and a different notice regarding your health information that is created in the physician's office.) Your information may be stored electronically and if so is subject to electronic disclosure.

I. We Are Legally Required to Safeguard Your Protected Health Information.

We are required by law to:

A. maintain the privacy of your health information, also known as "protected health information" or "PHI;"
B. notify you following a breach of unsecured PHI, under certain circumstances;
C. provide you with this Notice, and
D. comply with this Notice.

II. Future Changes to Our Practices and This Notice.

We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you previously. If a change in our practices is material, we will revise this Notice to reflect the change. You may obtain a copy of any revised Notice by contacting the Ethics & Compliance Department at 877-835-5267. We will also make any revised Notice available on our website at www.evhc.net.

III. How We May Use and Disclose Your Protected Health Information.

The law requires us to have your authorization for some uses and disclosures. In other circumstances, the law allows us to use or disclose PHI without your authorization. This section gives examples of each of these circumstances

Uses and Disclosures That Require Us to Give You the Opportunity to Object. Unless you object, we may provide relevant portions of your PHI **to a family member, friend or other person you indicate** is involved in your health care or in helping you get payment for your health care. We may use or disclosure your PHI to notify your family or personal representative of your location or condition. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it later, after the emergency, and give you the opportunity to object to future disclosures to family and friends. Unless you object, we may also disclose your PHI to persons performing disaster relief activities.

A. Certain Uses and Disclosures Do Not Require Your Authorization The law allows us to disclose PHI without your authorization in the following circumstances:

(1) When Required by Law.
(2) For Public Health Activities.
(3) For Reports About Victims of Abuse, Neglect or Domestic Violence.
(4) To Health Oversight Agencies.
(5) For Lawsuits and Disputes.
(6) To Law Enforcement. We may release PHI if asked to do so by a law enforcement official, in the following circumstances: (a) in response to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) about a death we believe may be due to criminal conduct; (e) about criminal conduct at our facility; and (f) in emergency circumstances, to report a crime, its location or victims, or the identity, description or location of the person who committed the crime.
(7) To Coroners, Medical Examiners and Funeral Directors.
(8) To Organ Procurement Organizations.
(9) For Medical Research. We may disclose your PHI without your authorization to medical researchers who request it for approved medical research projects
(10) To Avert a Serious Threat to Health or Safety.
(11) For Specialized Government Functions.
(12) To Workers' Compensation or Similar Programs.

IV. Other Uses and Disclosures of Your Protected Health Information.

Other uses and disclosures of your PHI that are not covered by this Notice or the laws that apply to us will be made only with your written authorization. The law also requires your written authorization before we may use or disclose: (i) psychotherapy notes, other than for the purpose of carrying out our treatment, payment or health care operations purposes, (ii) any PHI for our marketing purposes or (iii) any PHI as part of a sale of PHI. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclosure your PHI for the purposes specified in the written authorization, except that we are unable to retract any disclosures we have already made with your permission.

In addition, we can use or disclose your PHI after you have revoked your authorization for actions we have already taken in reliance on your authorization. We are also required to retain certain records of the uses and disclosures made when the authorization was in effect.

V. Your Rights Related to Your Protected Health Information.

You have the following rights:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us to limit how we use and disclose your PHI. Any such request must be submitted in writing to our Privacy Officer. We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment. Notwithstanding the foregoing, we must agree to a restriction on the use or disclosure of your PHI if: (i) the disclosure is for our payment or health care operations purposes and is not otherwise required by law and (ii) you or another person acting on your behalf has paid for our services in full.

B. The Right to Choose How We Communicate With You. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail, or never by telephone). We must agree to your request as long as it would not be disruptive to our operations to do so. You must make any such request in writing, addressed to our Privacy Officer.

C. The Right to See and Copy Your PHI. Except for limited circumstances, you may look at and copy your PHI if you ask in writing to do so. Any such request must be addressed to our Patient Billing Service Center, which will respond to your request within 10 days (or 30 days if the extra time is needed). In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If we keep your information in an electronic format, you may request that we provide it to you in that format and we will do so if it would be feasible.

D. The Right to Correct or Update Your PHI. If you believe that the PHI we have about you is incomplete or incorrect, you may ask us to amend it. Any such request must be made in writing and must be addressed to our Patient Billing Service Center, and must tell us why you think the amendment is appropriate. We will not process your request if it is not in writing or does not tell us why you think the amendment is appropriate. We will act on your request within 30 days or less if state law requires (or 60 days if the extra time is needed), and will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will ask you who else you would like us to notify of the amendment.

We may deny your request if you ask us to amend information that:

(1) was not created by us, unless the person who created the information is no longer available to make the amendment;
(2) is not part of the PHI we keep about you;
(3) is not part of the PHI that you would be allowed to see or copy; or
(4) is determined by us to be accurate and complete.

If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement or complaint, or to request inclusion of your original amendment request in your PHI.

E. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI going back six years from the date of your request. The list will not include disclosures we have made for our treatment, payment and health care operations purposes, those made directly to you or your family or friends or through our facility directory, or for disaster relief purposes. Neither will the list include disclosures we have made for national security purposes or to law enforcement personnel.

Your request for a list of disclosures must be made in writing and be addressed to the Billing Center address that is listed on your invoice. We will respond to your request within 30 days, or less if state law requires (or 60 days if the extra time is needed). The list we provide will include disclosures made within the last six years unless you specify a shorter period. The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the 12-month period.

F. The Right to Get a Paper Copy of This Notice. Even if you have agreed to receive the Notice by e-mail, you have the right to request a paper copy as well. You may obtain a paper copy of this Notice by contacting the Ethics & Compliance Department at 877-835-5267. The Notice is also available on-line at www.evhc.net.

VI. Complaints.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the federal Department of Health and Human Services. To file a compliant with the DHHS put your complaint in writing and address it to the U S Department of Health & Human Services, 200 Independence Ave. S.W., Washington DC, 20201. Or call them at 877-696-6775. To file a complaint with us, put your complaint in writing and address it to our Envision Healthcare Corporation HIPAA Privacy Officer at Envision Healthcare Corporation 1A Burton Hills Blvd, Nashville, TN 37215. You may also contact our Privacy Officer at 877-835-5267 to file a complaint, or if you have questions or comments about our privacy practices. We will not retaliate against you for filing a complaint.

Effective Date:
Revision Date: May 10, 2017

Essential Healthcare Group-Oregon Digestive
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Patient's Bill of Rights

As a patient of **ESSENTIAL HEALTHCARE GROUP - Delaware,** you have the right to receive the following information:

Patient's Bill of Rights:

Every patient has the right to be treated as an individual with his or her rights respected. The practice and medical staff have adopted the following list of patient's rights:

Patient's Rights:

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To be treated with respect, consideration, and dignity in receiving care, treatment, and/or services.
- To be provided privacy and security of self and belongings during the delivery of patient care service.
- To receive information from his/her physician about his/her illness, his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
- To receive as much information about any proposed treatment or procedures as he/she may need in order to give informed consent prior to the start of any procedure or treatment.
- When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.
- To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.
- To be free from mental and physical abuse, free from exploitation, & free from use of restraints.
- Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.
- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and shall be conducted discretely.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission shall be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care. The facility has established policies to govern access and duplication of patient records.
- Leave the facility even against the advice of his/her physician.
- Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care

- Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge for the facility.
- To know the identity and professional status of individuals providing services to them, and to know the name of the physician who is primarily responsible for coordination of his/her care.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient's rights.
- To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's usual care. The patient has written consent for participation in research shall be obtained and retained in his or her patient record.
- Examine and receive an explanation of his/her bill regardless of source of payment.
- To appropriate assessment and management of pain.

If you need a translator:

If you will need a translator, please let us know and one will be provided for you. If you have someone who can translate confidential, medical and financial information for you please arrange to have him or her accompany you on the day of your procedure.

Rights and Respect for Property and Person

The patient has the right to:

- Exercise his or her rights without being subjected to discrimination or reprisal
- Voice grievance regarding treatment or care that is of fails to be furnished
- Be fully informed about a treatment or procedure and the expected outcome before it is performed
- Confidentiality of personal medical information
- Privacy and Safety

The patient has the right to:

- Personal privacy
- Receive care in a safe setting
- Be free from all forms of abuse or harassment

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Advance Directives

You have the right to information on the practice's policy regarding Advance Directives.

Advance Directives will not be honored within the practice. In the event of a life-threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes. If you request, an official state Advance Directive Form will be provided to you.

Submission and Investigation of Grievances:

You have the right to have your verbal or written grievances submitted, investigated and to receive a written notice of the Center's decision.

The following are the names and/or agencies you may contact:

You may contact your state representative to report a complaint; www.cdc.gov/mmwr/about.html State website: https://legis.delaware.gov/SessionLaws/Chapter?id=25037. Sites for address and phone numbers of regulatory agencies: Medicare Ombudsman website: www.medicare.gov/Ombudsman/resources.asp Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227), Office of the Inspector General: http://oig.hhs.gov

_____

Signature of Patient or Patient Legal Representative

Date

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Provider:
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Patient Financial Agreement

Please read the following information closely. If you have any questions, please ask. We want to ensure that you completely understand our financial policies.

1. Essential Healthcare Group (EHG) - Delaware participates with Medicare, Medicaid and many commercial insurances. While EHG may have an agreement with your insurance, it is your responsibility to know if your plan is in network. By contract, covered charges will be paid directly to EHG. Any applicable co-insurance payments and/or deductibles are due at the time of service. Failure to make the appropriate co-payment at the time of your office visit may result in the re-scheduling of your medical appointment.

2. When an account balance becomes your responsibility, the balance is due upon receipt of the first account statement from EHG-Delaware. If any part of the account balance becomes delinquent, then the account balance may be forwarded to an outside agency for collection. A $35 returned check fee might be assessed for non-sufficient funds.

3. If you make an appointment for a wellness visit or physical and your doctor treats you for an illness or counsels you regarding a medical condition during the visit, there could be a separate co-payment that is your responsibility.

4. A deposit of $100 is required for all patients who do not have insurance; have insurance that is not contracted with EHG; or have an Out-of-Area Primary Care Physician.

5. During your appointment, your provider may order additional medical services, such as laboratory tests, which will need to be sent out of the clinic to be processed. In this case, you may receive a separate bill from an external company, which will be your responsibility.

I understand that it is my responsibility to know what the terms of my insurance are, and in compliance with those terms, agree to the following:

1. I will pay all applicable co-pays and outstanding balances as they become due.

2. I assign medical benefits paid by my insurance carrier(s) to EHG, for application to my bill. I acknowledge that I will be billed for charges not covered under my insurance policy.

3. I hereby authorize EHG to furnish the insurance company, payers or their representatives, all information required to process my claims, which may include treatment/testing for HIV-related conditions.

4. I have read and understand EHG's financial agreement and I agree to be bound by its terms. I understand that my refusal to sign this form will be interpreted as my decision to cease receiving medical care with EHG.

_____ _____
Patient Signature **Date**

_____
Print Patient Name

_____
Print Responsible Party Name (if different from patient)

_____
Essential Healthcare Group - Delaware

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Patient Acknowledgement Form

Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices and know that I may request a personal copy if I so choose.

_____ _____
Patient/Responsible Party Signature **Date Signed**

_____
Patient/Responsible Party Printed Name

Patient Financial Agreement

By signing below, I acknowledge that I have reviewed the Patient Financial Agreement and know that I may request a personal copy if I so choose.

_____ _____
Patient/Responsible Party Signature **Date Signed**

_____
Patient/Responsible Party Printed Name

Patient Bill of Rights

By signing below, I acknowledge that I have reviewed the Patient Bill of Rights and know that I may request a personal copy if I so choose.

_____ _____
Patient/Responsible Party Signature **Date Signed**

_____
Patient/Responsible Party Printed Name

Essential Healthcare Group - Oregon Digestive
New Patient
Patient Medical History

CHIEF COMPLAINT / REASON FOR VISIT

In your own words please describe the reason for your visit:

Review of Symptoms: Check any item you have experienced within the past year:

GASTROINTESTINAL
- ☐ Belching
- ☐ Bloody or Black Stools
- ☐ Change in Stools
- ☐ Constipation
- ☐ Difficulty Swallowing
- ☐ Excessive Gas
- ☐ Food intolerance
- ☐ Heartburn/Esophageal Reflux
- ☐ Hemorrhoids
- ☐ Loose bowels/diarrhea
- ☐ Nausea / Vomiting
- ☐ Recurrent Abdominal pain

HEART
- ☐ Discoloration of hands/feet
- ☐ Swollen feet/ankles
- ☐ Check pain/discomfort

LUNGS
- ☐ Shortness of Breath
- ☐ Persistent Cough
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Coughing up phlegm
- ☐ Difficulty Breathing

URINARY
- ☐ Frequent urination
- ☐ Bloody urine
- ☐ Difficulty urinating
- ☐ Incontinence
- ☐ Leaking urine
- ☐ Pain or burning on urination
- ☐ Unusually large volumes of urine
- ☐ Up at night to urinate?
- ☐ Sexual difficulty

MENTAL HEALTH / MOOD
- ☐ Depressed or Sad
- ☐ Irritable or Angry
- ☐ Anxious, Tense or Worried
- ☐ Fearful
- ☐ Sleep problems
- ☐ Loss of interest in activities
- ☐ Suicidal Thoughts
- ☐ Memory/Conentration problems
- ☐ Compulsive behaviors
- ☐ Stress

EYES
- ☐ Eye pain
- ☐ Change in vision
- ☐ Blind spells

BONES / JOINTS
- ☐ Back/neck pain
- ☐ Muscle cramps
- ☐ Stiff/painful joints
- ☐ Pain down back of legs
- ☐ Pain in legs when walking
- ☐ Swelling in legs
- ☐ Redness in joints

GENERAL
- ☐ Change in heat/cold tolerance
- ☐ Persistent fever
- ☐ Chills/cold intolerance
- ☐ Appetite/Thirst changes
- ☐ Night sweats
- ☐ Swollen glands
- ☐ Unusual weakness / fatigue
- ☐ Weight gain/loss

NEUROLOGIC
- ☐ Coordination problems
- ☐ Dizziness / Fainting
- ☐ Headaches
- ☐ Difficulty speaking
- ☐ Loss of balance
- ☐ Loss of sensation
- ☐ Muscle weakness
- ☐ Numbness/tingling

EAR / NOSE / THROAT
- ☐ Earache / Infection / Drainage
- ☐ Hearing loss / Ringing in ears
- ☐ Bleeding gums
- ☐ Sinus trouble
- ☐ Hoarseness
- ☐ Neck swelling / lumps
- ☐ Sores in mouth
- ☐ Nose bleeds / nasal polyps

BREASTS / FEMALE
- ☐ Nipple Discharge/bleeding
- ☐ Lump in breast
- ☐ Pain in breast
- ☐ Heavy menstrual bleeding
- ☐ Irregular menstrual periods
- ☐ Vaginal Discharge
- ☐ Premenstrual symptoms

ALLERGY / SKIN
- ☐ Allergy
- ☐ Nail Change
- ☐ Unusual hair loss
- ☐ Ulcers
- ☐ Bruise easily
- ☐ Change in skin/mole
- ☐ Dryness of skin / rash / hives

Have you had any of the following diagnostic testing completed regarding to this most recent visit?

☐ MRI ☐ CT Scan ☐ Blood test ☐ Ultrasound ☐ X-ray ☐ Other _____

MEDICATIONS / ALLERGIES

Please list all current medications, dosages & frequency of use:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Are you currently taking any blood thinner? ____Yes ____No

Are you allergic to any medications? ____No ____Yes If yes, which medications? _____

PERSONAL/FAMILY MEDICAL HISTORY

Have you or a family member ever been diagnosed with the following?

GASTROINTESTINAL

Self	Family	
☐	☐	Crohns Disease
☐	☐	Irritable Bowel Syndrome
☐	☐	Ulcerative Colitis
☐	☐	Acid Reflux/GERD
☐	☐	Colon Polyp(s)
☐	☐	Diverticulitis
☐	☐	Ulcers
☐	☐	Liver Disease

Self	Family	
☐	☐	Pancreas Disease
☐	☐	Gallbladder Disease
☐	☐	Swallowing Disorder
☐	☐	GI Bleeding
☐	☐	Microscopic Colitis
☐	☐	Celiac Disease
☐	☐	Anemia
☐	☐	Colitis

HEART / VASCULAR

Self	Family	
☐	☐	Heart attack
☐	☐	Coronary Artery Disease
☐	☐	Congestive Heart Failure
☐	☐	Abdominal Aortic Anuerysm
☐	☐	Atrial Fibrillation
☐	☐	Hypertension
☐	☐	Vascular Disease
☐	☐	DVT

GENERAL

Self	Family	
☐	☐	Asthma
☐	☐	Sleep Apnea
☐	☐	COPD
☐	☐	High Cholesterol
☐	☐	Cancer (type _____)
☐	☐	Hepatitis
☐	☐	Thyroid Disease
☐	☐	Diabetes

Other Diagnosis not listed: _____

Tobacco Use: ____No ____Yes If yes, frequency & type: _____

Alcohol Use: ____No ____Yes If yes, frequency & type: _____

SURGICAL HISTORY

Have you had any of the following surgeries or procedures? If yes, please list year.

	Year		Year		Year		Year
☐ Appendectomy	_____	☐ Hysterectomy	_____	☐ Gastric Bypass	_____	☐ Splenectomy	_____
☐ Gall Bladder Removal	_____	☐ Hernia	_____	☐ Lap Band	_____	☐ Mastectomy	_____
☐ Heart Surgery	_____	☐ Kidney Surgery	_____	☐ Tubal Ligation	_____		
☐ Colon Resection	_____	☐ Stomach Surgery	_____	☐ Pacemaker	_____		

Other Surgery Not Listed: _____

Have you ever had an upper endoscopy / EGD? ____Yes ____No If yes, when/where/by whom? _____

Have you ever had a lower endoscopy / Colonoscopy? ____Yes ____No If yes, when/where/by whom? _____