Palmetto Gastro & Hepatology
Specialized Digestive Care
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Patient Information Form

PATIENT INFORMATION

ACCOUNT #	TITLE	LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER

STREET ADDRESS	APARTMENT OR P.O. BOX

CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	EMERGENCY CONTACT (NAME & PHONE)
( ) –	( ) –	/( ) –

BIRTHDAY (MM/DD/YYYY)	SEX(M. F.)	RACE (EX. WHITE, ASIAN, ETC.)	FAMILY DOCTOR

MARITAL STATUS	EMPLOYEMENT	STUDENT	REL. TO INSURED
S-Single	F-Full	F-Full	SE-Self
M-Married	P-Part	P-Part	SO-Spouse
D-Divorced	R-Retired	N-None	OT-Other
W-Widowed	N-None		CH-Child
X-Separated			

I authorize the release of any medical or other information necessary to process insurance claims.

Signature Date

I authorize the payment of medical benefits directly to this practice for the services rendered.

Signature Date

Email

Please check one as your preferred email for communications.

Personal:_____ Work: _____

Preferred Language

English Spanish Patient Declines to Specify

Contact Preference

Portal Email Letter Cell Phone Telephone Call - Home

No Preference Patient Declines to Specify

Pharmacy

( ) –

Name Address Phone

Allergies

Patient has no known allergies Patient has no known drug allergies

Penicillins Codeine Morphine Sulfa Latex Other

Current Medications

☐ None

Name	Dose	How taken?

Diagnostic Studies/Tests

☐ None

☐ EGD
When: _____

☐ Colonoscopy
When: _____

☐ ERCP
When: _____

☐ MRI
When: _____

☐ Abdominal Ultrasound
When: _____

☐ CT Abdomen/Pelvis
When: _____

☐ Recent blood workup
When: _____

Past or Present Medical Conditions

☐ None

GI

☐ GERD/Heartburn
☐ Esophageal Structure
☐ Esophageal Varices
☐ Ulcers
☐ Gastrointestinal Cancer
☐ Liver Disease
☐ Ulcerative Colitis/Crohn's Disease
☐ Irritable Bowel Syndrome
☐ H. Pylori Infection
☐ Acute Pancreatitis
☐ Cirrhosis
☐ Colon Polyp History
☐ Malabsortive Disorder
☐ Infectious Diarrhea
☐ Barrett's Esophagus
☐ Diverticulosis
☐ Crohn's Disease
☐ Lactose Intolerance
☐ Fatty Liver (NASH)
☐ CVA
☐ Hepatitis _____

Cardionvascular

☐ Atrial Fibrilation
☐ Coronary Heart Disease
☐ Deep Vein Thrombosis
☐ Endocarditis
☐ High Blood Pressure
☐ Myocardial Infarction
☐ Stents

Pulmonary

☐ Asthma
☐ Emphysema

Other

☐ Arthritis
☐ Back Pain (Chronic)
☐ Diabetes Mellitus
☐ Glaucoma
☐ Hypothyroidism
☐ Renal Insufficiency
☐ HIV

Previous Procedures

☐ None

☐ Hysterectomy
When: _____

☐ Appendectomy
When: _____

☐ Cholecystectomy -Laparoscopic
When: _____

☐ Back/Spine Surgery
When: _____

☐ Other Surgery
When: _____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Unknown
- Civil Union
- Other

Alcohol

- None
- Less than 7 per week
- More than 7 per week
- Date Quit: _____

Caffeine

- None
- Coffee, Tea, Soda

Intake:_____

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: _____ Quit: _____ Quantity: _____

Drug Use

- None
- Uses IV drugs currently
- Used IV drugs in the past
- Recreational drug use

Exercise

- None
- Mild
- Moderate
- Strenuous

Past or Present Medical Conditions

- No knowledge of family history

No family history of

- Celiac Sprue
- Ulcerative Colitis/ IBD
- Liver Disease
- Colon Polyps
- Colon Cancer

Diagnoses

Check on the corresponding box if the person had it.

	Mother	Father	Sister	Brother	Daughter	Son	Other
Colon Cancer							
Celiac Disease							
Colon Polyps							
Liver Disease							
Ulcerative Colitis/IBD							

Review of Systems

- **Cardionvascular**
  - None

	Y	N
chest pain	○	○
palpitations	○	○
peripheral edema	○	○

- **Constitutional**
  - None

	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
weight loss	○	○

- **ENMT**
  - None

	Y	N
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
hearing loss	○	○

- **Endocrine**
  - None

	Y	N
excessive thirst	○	○
heat intolerance	○	○

- **Eyes**
  - None

	Y	N
loss of vision	○	○

- **Gastrointestinal**
  - None

	Y	N
abdominal pain	○	○
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○
fecal incontinence	○	○

- **Genitourinary**
  - None

	Y	N
dark urine	○	○
dysuria	○	○
frequent urination	○	○
hematuria	○	○

- **Hematologic/Lymphatic**
  - None

	Y	N
easy bruising	○	○
prolonged bleeding	○	○

- **Integumentary**
  - None

	Y	N
itching	○	○
jaundice	○	○
rashes	○	○

- **Musculoskeletal**
  - None

	Y	N
back pain	○	○
joint pain	○	○
muscle weakness	○	○

- **Neurological**
  - None

	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
memory loss	○	○

- **Psychiatric**
  - None

	Y	N
anxiety	○	○
depression	○	○

- **Respiratory**
  - None

	Y	N
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
wheezing	○	○

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

Reviewed with _____

Patient Parent Guardian Not Present

Signature _____

_____
Signature Date

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 and demographic information shared with other health care entities.
Yes No

PALMETTO GASTROENTEROLOGY AND HEPATOLOGY, PA

Acknowledgement and Receipt of Notice of Privacy Practice

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting a request. By signing this form, you acknowledge receipt of our notice regarding the use and disclosure of protected health information about you for treatment, payment and health care operations as described in the notice.

Yes No I authorize PALMETTO GASTROENTEROLOGY AND HEPATOLOGY, PA to call my home and leave a message.

Yes No I authorize PALMETTO GASTROENTEROLOGY AND HEPATOLOGY, PA to call my work and leave a message.

Please list anyone whom you want to have verbal and/or physical access to your health care information. This information will remain in place until you direct us otherwise.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: Practice Manager, 85 Wren Street, Barnwell, South Carolina, 29812. I understand that a revocation is not effective to the extent that PALMETTO GASTROENTEROLOGY AND HEPATOLOGY, PA. has relied on the use or disclosure of the protected health information. Unless otherwise revoked, this authorization will expire in one year from date of authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law.

PALMETTO GASTROENTEROLOGY AND HEPATOLOGY, PA. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use of disclosures.

I understand I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law or state law. I have the right to refuse to sign this authorization.

Patient/Personal Representative Signature: _____ **Date:** _____

Patient/Personal Representative Name: _____

Description of Personal Representative's Authority: _____