



# 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 <input type="checkbox"/> S-Single <input type="checkbox"/> M-Married <input type="checkbox"/> D-Divorced <input type="checkbox"/> W-Widowed <input type="checkbox"/> X-Separated	EMPLOYMENT <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> R-Retired <input type="checkbox"/> N-None	STUDENT <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None	REL. TO INSURED <input type="checkbox"/> SE-Self <input type="checkbox"/> SO-Spouse <input type="checkbox"/> OT-Other <input type="checkbox"/> CH-Child	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 ( ) -
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## 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

<b>GI</b>	<input type="checkbox"/> GERD/Heartburn	<input type="checkbox"/> Esophageal Structure	<input type="checkbox"/> Esophageal Varices	<input type="checkbox"/> Ulcers
	<input type="checkbox"/> Gastrointestinal Cancer	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Ulcerative Colitis/Crohn's Disease	<input type="checkbox"/> Irritable Bowel Syndrome
	<input type="checkbox"/> H. Pylori Infection	<input type="checkbox"/> Acute Pancreatitis	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Colon Polyp History
	<input type="checkbox"/> Malabsorptive Disorder	<input type="checkbox"/> Infectious Diarrhea	<input type="checkbox"/> Barrett's Esophagus	<input type="checkbox"/> Diverticulosis
	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Fatty Liver (NASH)	<input type="checkbox"/> CVA
			<input type="checkbox"/> Hepatitis _____	
<b>Cardiovascular</b>	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Coronary Heart Disease	<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> Endocarditis
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> Stents	
<b>Pulmonary</b>	<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema		
<b>Other</b>	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Back Pain (Chronic)	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Glaucoma
	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Renal Insufficiency	<input type="checkbox"/> 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

## • Cardiovascular

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

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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: \_\_\_\_\_