KENNETH M. HOLT, M.D., F.A.C.P.
JAMES A. SATTLER, M.D.
KARL K. FUKUNAGA, M.D.

DIGESTIVE CARE CONSULTANTS

THAI Q. HA, M.D.
AZAM S. RIYAZ, M.D.
CHIRAG P. PATEL, M.D.
SHAHINA HAKIM, M.D.

PATIENT INFORMATION FORM

Please print all information in the spaces provided.

PATIENT NAME _____ SEX: F____ M____
LAST FIRST M.I.

ADDRESS _____ HOME PHONE # _____

CITY _____ STATE_____ ZIP_____ CELL PHONE # _____

E-MAIL ADDRESS _____ MARITAL STATUS_____

DATE OF BIRTH _____/_____/_____ AGE:_____ SOCIAL SECURITY # _____

EMPLOYER _____ PHONE # _____

OCCUPATION _____

ADDRESS _____

EMERGENCY CONTACT NAME _____ PHONE # _____

FAMILY PHYSICIAN _____ PHONE # _____

INSURANCE INFORMATION: *(PLEASE COMPLETE IN FULL) HMO____ PPO____ PVT____ POS____*

MEDICARE #_____ MEDI-CAL # _____

PRIMARY INSURANCE

INS. CO. NAME _____

POLICY HOLDER NAME _____

RELATIONSHIP: SELF_____ SPOUSE_____

INS. ID# _____

SECONDARY INSURANCE

INS. CO. NAME _____

POLICY HOLDER NAME _____

RELATIONSHIP: SELF_____ SPOUSE_____

INS. ID# _____

I hereby authorize payment of medical benefits billed to my insurance to Digestive Care Consultants. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all co-payments, co-insurance, and deductibles at the time the service is rendered.

_____ _____

Signature of patient or guardian *date*

_____ _____

Printed Name of Patient's Representative *Relationship to the Patient*

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Patient's Personal History

DATE:_____

Name _____ Date of Birth _____

Home Phone _____ Age _____ Height _____ Weight _____

Occupation _____ Referring Physician _____ Date of last exam _____

Why are you here today _____

_____

PAST HISTORY

ILLNESSES (NOT requiring hospitalization)		**ILLNESSES** (requiring hospitalization)		**SURGERIES**	
Year	*Type of Illness*	*Year*	*Type of Illness*	*Year*	*Type of Illness*

ALLERGIES

Are you allergic to any foods? ☐ No ☐ Yes

Medicine or Food

_____

_____

_____

_____

Are you allergic to any medications ☐ No ☐ Yes

Type of Reaction

_____

_____

_____

_____

MEDICATIONS

(Include Vitamins, herbal supplements, over-the-counter meds. etc)

Medication	*Dose*	*Frequency*

PERSONAL HABITS (circle yes or no)

Yes No Do you regularly smoke? Cigarettes Pipe Cigars
How much?_____ How long?_____ Quit Date_____

Yes No Do you drink alcohol? If yes, what kind/how much per day?_____

Yes No Do you or have you used recreational drugs? What type?_____

FAMILY HISTORY

	IF LIVING: Age	Health	*IF DECEASED:* Age (at Death)	Cause
Father	____	_____	____	_____
Mother	____	_____	____	_____
Brother/Sister	____	_____	____	_____
	____	_____	____	_____

REVIEW OF SYSTEMS

(Circle "yes" if you currently have any of the following)

HEAD/NECK (Circle One)

Yes	No	Headaches	Yes	No	Nosebleeds
Yes	No	Eye disease, glaucoma	Yes	No	Itchy eyes, runny nose, hay fever
Yes	No	Convulsions, seizures	Yes	No	Sinus trouble
Yes	No	Double Vision	Yes	No	Numbness or weakness in arm or leg
Yes	No	Dizziness, fainting	Yes	No	Trouble swallowing
Yes	No	Pain, ringing in ears	Yes	No	Hoarseness in voice
Yes	No	Decreased hearing	Yes	No	Stiffness in neck

RESPIRATORY (Circle one)

Yes	No	Chronic cough
Yes	No	Asthma, wheezing
Yes	No	Shortness of breath
Yes	No	Cough up blood / serum

CARDIOVASCULAR (Circle one)

Yes	No	Chest pain / pressure / tightness
Yes	No	Shortness of breath when lying down
Yes	No	Palpitations
Yes	No	Shortness of breath with exertion

GASTROINTESTINAL (Circle one)

Yes	No	Heartburn / indigestion	Yes	No	Gallbladder trouble
Yes	No	Intolerance to spicy foods	Yes	No	Abdominal Pain
Yes	No	Frequent vomiting	Yes	No	Bloody or black stools
Yes	No	Nausea	Yes	No	Use of antacids
Yes	No	Chronic constipation	Yes	No	Use of antacids
Yes	No	Frequent diarrhea			

GENITOURINARY (Circle one)

Yes	No	Loss of urine with cough or sneeze
Yes	No	Burning or painful urination
Yes	No	Frequent need to urinate
Yes	No	Blood in urine
Yes	No	Swelling in hands and feet
Yes	No	Difficulty in urinating

MUSCULOSKELETAL (Circle one)

Yes	No	Arthritis
Yes	No	Pain in joints
Yes	No	Varicose veins
Yes	No	Pain in calves / hips when walking
Yes	No	Cramps in legs at night
Yes	No	Pain in big toe

GYNECOLOGICAL

(This section for women only)

Age when periods started _____ Last period_____

Date of last PAP smear_____ Normal? ☐ Yes ☐ No

If pre-menopausal, are periods normal? ☐ Yes ☐ No

Age at menopause, if applicable _____

Number of: Pregnancies_____ Deliveries_____ Miscarriages_____

Year of last mammogram_____ Normal? ☐ Yes ☐ No

Year of last bone density test_____

COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Date