TDDC
Texas Digestive Disease Consultants
GREATER HOUSTON GASTROENTEROLOGY

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Office: 281-764-9500 **Fax: 281-764-9501**

Thank you for choosing Texas Digestive Disease Consultants for your health care needs.

Attached is our new patient packet. As a reminder, there is an electronic version of these forms available for you to complete at the time of your appointment. However, if you're more comfortable with completing the forms by hand, please do so and bring the documents with you to your appointment. **Please DO NOT return your forms via email**.

In order to expedite your check in process, please register on our NEW patient portal prior to your appointment. You should have received an invitation to the portal at the time you scheduled your appointment. If you did not receive it, please call our office and we will be happy to resend the invite. Please complete the Health Summary section and click "SEND". This allows us to update your information instantly and save you time at check in!

If you did not complete this online Health Summary Section prior to your visit, you are required to check in 30 minutes prior to your scheduled appointment; otherwise, you only need to check in 15 - 20 minutes prior to your appointment.

What to bring:

1. Patient Packet Documents
   - Page 4, Form 7.34, Disclosure of PHI via alternate means
   - Page 5, Form 7.31, Limited Disclosure of PHI
   - Pages 9 - 14, **IF** you did not register on the patient portal
2. Insurance Card
3. Drivers License or State Issued ID
4. Medical Records, if applicable
5. Insurance Authorized Referral from your Primary Care, if applicable
6. Specialist Co-payment, which will be collected upon check-in. We accept Cash, Checks, Visa, MasterCard, and Discover.

Our office will verify your insurance eligibility and benefits 1 - 2 days prior to your appointment. We will make every effort to contact you prior to your appointment if we need additional information regarding your insurance coverage. However, it is important that you too verify our provider's participation to your insurance network and check if an authorized referral from your insurance carrier is required.

Please note, if you have an EPO or HMO plan, an authorized referral from your insurance carrier **WILL** be required. We would appreciate your assistance in obtaining one from your PCP for insurance carriers do not allow us to initiate these authorization requests. When contacting your PCP, please inform them to obtain the authorization for evaluation and treatment.

Please contact our office at 281-764-9500 should you need to cancel or reschedule your appointment.

We appreciate the opportunity to participate in your care.

Notice of Privacy Practices

Form 7.20

Texas Digestive Disease Consultants

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as neceesary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

(214) 424-2200

We will not retaliate against you for filing a complaint.

Effective Date 9/23/2013 Publication Date 9/23/2013

Patient Authorization for Disclosure of Protected Health Information via Alternative Means **Form 7.34**

Please print all information, then sign and date authorization form at bottom.

Patient Name: _____ **Date of Birth:** _____

Purpose of Authorization – It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, *"by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care."* The practice requires the following authorization for release of protected health information (PHI) via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

☐ cell phone: ☐ email address: ☐ US Mail: ☐ fax number: ☐ phone:

_____

Description of information to be disclosed - I authorize the practice to disclose the following PHI about me. *(Provide a written description of the information to be disclosed.)*:

_____

_____

Purpose of disclosure – I am authorizing the alternative means of communication for disclosure of my PHI to ensure the confidentiality of communications from the practice.

Expirations or termination of authorization – This authorization will renew automatically, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

(Please list desired expiration date): _____

Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in person or by mailing a written request to the practice, Attn: Privacy Manager.

Non-Conditioning Statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

Redisclosure Statement – I understand that the practice has no control regarding persons who may have access to the mailing or email address, telephone, cell or fax number I have designated to receive my PHI. Therefore, I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.

Secure Communication – Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email as your preferred method of communication if this is of concern to you.

_____ _____

patient signature date

Copies of signed authorizations are available upon request.

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Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information:

Texas Digestive Disease Consultants

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays;
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.

Patient Instructions for Form 7.31

Limited Patient Authorization for Disclosure of Protected Health Information

The Limited Patient Authorization will give our office the authority to provide the person or entity you designate on the form with access to your protected health information (PHI). The Limited Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to a person or entity that may be involved in your healthcare.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

Patient Name - Print your name.

Social Security Number and Date of Birth - This information is needed for identity verification and will be maintained in a confidential manner at all times.

Entity Requested to Release information - This simply identifies who is to provide the information.

Purpose of Request- To disclose your protected health information to an individual.

Who will be authorized to receive information – Enter the name, address and phone number of the individual or entity that you are designating to receive the disclosure.

Description of Information to be disclosed - The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

Purpose of Disclosure - Regulations require that we identify the purpose for disclosing limited information. You also have the right to keep the purpose to yourself by selecting "Patient Request."

Expiration or Termination - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information by verifying your wish to continue the authorization for disclosure.

Right to Revoke or Terminate - You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

Non-Conditioning Statement - This simply states that our practice does not place conditions for treatment on the use of the authorization.

Redisclosure Statement - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

Signature and Date - We will need your signature and date of the signature to make the authorization effective.

Copies - We will provide you with a copy of this signed authorization upon request.

 (800) 777-2337

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PLEASE READ THIS VERY IMPORTANT INFORMATION REGARDING YOUR PROCEDURE.

You have been scheduled for a gastroenterology procedure(s) under the care of a TDDC physician. TDDC wants to help by providing you the following information related to health plans and insurance that may affect processing of your claims.

- TDDC will work with your health plan representatives to obtain prior authorization for your gastroenterology procedure(s). Therefore, **it is imperative that TDDC is furnished with your applicable and current insurance information.**

- If your insurance plan requires a **referral authorization from a primary care physician, please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance company may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges.**

- TDDC will seek to verify medical benefits for planned procedures under your health plan. **If insurance verification indicates your services will not be covered, or that a significant portion of the cost will be your responsibility, our staff will attempt to contact you** to discuss your payment options prior to your procedure. **Whether you have been contacted or not, you are responsible for any balance after insurance processes your claim.**

- Employers now choose to purchase from a wide array of health care plans. Your health plan may have a benefit structure that will determine your out of pocket cost. We make every possible effort to obtain accurate benefits; however, our information is only as good as that provided by the health plan representatives. **For this reason, we urge you to review the health plan coverage information given to you by your employer or insurer to gain your own understanding of your insurance benefits.**

- **TDDC wants you to understand health plans may have different benefit structures for screening / diagnostic / therapeutic / surgical services**. Some services performed by gastroenterologists are done for "preventive" purposes (diagnostic) as a screening colonoscopy or screening due to family history of colon cancer or polyps. These same services can be performed because patients are experiencing signs or symptoms of illness and intervention / surgery may become part of the service provided. **Please refer to the colonoscopy informational insert if scheduled for this procedure as often a colonoscopy performed due to a personal history of polyps will be processed with the same benefits as a medical colonoscopy**.

- **TDDC wants you to be aware there will be charges related to your services from other health care providers in addition to our physician performing your procedure including :**
  The **facility** in which you receive you care
  The services of an **anesthesia provider.**
  The services of **pathologists** if biopsies taken or polyps removed

- **Hospital based physicians such as pathologists and anesthesia provider may be out of network for your health plan, even if the hospital and the TDDC physician is in-network**. TDDC physicians do not have control over other hospital based providers' health plan participation.

If you have any questions concerning your insurance benefits, it is your responsibility to contact customer service at your insurance company. They will be happy to help you with any questions that you may have.

ATTENTION PATIENTS

The following pages (the Patient Interview forms) can be completed electronically via our patient portal.

If you provided your email address at the time you scheduled your appointment, you should have received an invitation to the portal.

If you did not receive the invitation, please call our office at 281-764-9500 and we will be happy to resend the invite so that you can register on the patient portal and complete your Health Summary Section.

Otherwise, please take a moment to complete the following pages and bring them with you to your appointment.

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Patient Interview Form- Formulario de entrevista con el paciente

Patient Information - Información del paciente

First Name:_____ Last Name:_____
(Nombre) (Apellido)
MRN:_____ Date of Birth:_____
(No. Historia Clinica) (Fecha de nacimiento)
Age:_____
(Edad)

Email- Correo electrónico
Please check one as your preferred email for communications – (Marque uno como su correo electrónico preferido para las comunicaciones)
☐ Personal:_____ ☐ Work:_____
(Laboral)

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino (No Hispano o Latino) ☐ Patient declines to specify (El paciente no desea especificar) ☐ Prohibited by state law (Prohibido por ley estatal)

Race
Select one or more
☐ White (Blanca) ☐ Black or African American (Negro o afroamericano) ☐ Asian (Asiático) ☐ American Indian or Alaska Native (Indio americano o nativo de Alaska) ☐ Native Hawaiian or other Pacific Islander (Nativo de Hawái u otro isleño del Pacífico)

☐ Unknown (Desconocido) ☐ Patient declines to specify (El paciente no desea especificar) ☐ Prohibited by state law (Prohibido por ley estatal)

Preferred Language
☐ English (Inglés) ☐ Korean (coreano) ☐ Spanish; Castilian (Español; Castellano) ☐ Patient declines to specify (El paciente no desea especificar)

Contact Preference
☐ Telephone call (Llamada telefónica) ☐ Portal ☐ Patient declines to specify (El paciente no desea especificar) Other:_____ (Otro)

Allergies – Alergias

☐ Patient has no known allergies
El paciente no tiene alergias

☐ Patient has no known drug allergies
El paciente no tiene alergias

☐ Aspirin (Aspirina) ☐ Cipro (Cipro) ☐ Codeine (Codeina) ☐ Demerol ☐ Fentanyl
☐ Flagyl ☐ Iodine (Iodo) ☐ IV dye (Tinte) ☐ Levaquin ☐ Morphine (Morfina)
☐ Penicillins (Penicilinas) ☐ Versed (Versado) ☐ Sulfa ☐ Eggs (Huevos) ☐ Latex
☐ Nuts (Nueces) ☐ Shellfish (Mariscos) ☐ Manifestations/Reactions: (Manifestaciones/reacciones) _____ Other:_____ (Otro)

Immunizations - Vacunas

☐ None (Ninguno)

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Hepatitis B	Hepatitis A	Influenza Vaccine (Antigripal)	Pneumovax Vaccine	Tetanus vaccine (Antitetánica)
When:_____ Fecha:_____	When:_____ Fecha:_____	When:_____ Fecha:_____	When:_____ Fecha:_____	When:_____ Fecha:_____

Current Medications - Medicamentos actuales

None (Ninguno)

Name (Nombre) Dose (Dosis) How taken? (Como se toman)

Pharmacy - Farmacia

Name (Nombre) Address (Dosis) Phone (Telefono)

Past Medical History - Antecedentes médicos

None (Ninguno)

Cancers:
Colon; Esophageal (Esófago); Liver (Higado); Small Intestine (Intestino Delgado)
Stomach (Estómago); Kidney (Riñón); Pancreas; Bladder (Vejiga)
Lymphoma(Linforma); Lung(Pulmó; Skin (Piel); Prostate (Prostata)
Breast (Mama); Cervical; Ovarian (Ovarios); Uterine (Uterino)
Other:_____ (Otro)

Liver: (Hígado)
Fatty liver (Higado graso); Hepatitis A active(activa); Hepatitis B, active(activa); Hepatitis C, active(activa)
Hepatitis, autoimmune
Other:_____ (Otro)

Digestive: (Digestivo)
Acid Reflux (Reflujo Acido); Barrett's Escphagus (Esogago fe Barrett); Celiac sprue (Celiaquia); Cirrhosis of Liver (Cirrosis Hepatica)
Colon Polyps (Polipos Colon); Crohn's disease (Enfermedad de Crohn); Diverticulitis (infected)(infectada); Divertivulosis
H. pylori; Irritable bowel Syndrome (Colon irritable); Pancreatitis; Ulcer (Ulcera)
Ulcerative colitis (Colitis ulcerosa)
Other:_____ (Otro)

Miscellaneous: (Varios)
Anxiety/Panic attacks (Ataques de panico/ ansiedad); Arthritis(Artritis); Asthma (Asma); Atrial fibrillation (Fibrilacion auricular)
Congestive Heart failure (Insuficiencia cardiaca congestiva); Cornonary Artery Disease (Enfermedad de arteria coronaria); Depression (Depresion); Diabetes
Emphysema (Enfisema); Endometriosis; Fibromyalgia (Fibromialgia); Glaucoma
Heart attack (Ataque Cardiaco); High Blood Pressure (Hipertensio); High Cholesterol (Colesterol alto); HIV (VIH)
Kidney disease (Enfermedad renal); Lupus; Osteopenia; Osteoporosis
Seizure disorder (Trastorno Convulsivo Transitoria); Sleep apnea (Apnea de sueno); Stroke/TIA (ACV/ Isquemia); Thyroid (Hipertiroidismo), Overactive
Thyroid, Underactive (Hipotiroidismo)
Other:_____ (Otro)

Supplements - If using the patient portal , please enter through the medication section instead. (Suplementos: si usa el portal del paciente, ingrese a través de la sección de medicamentos)

Please list vitamins (Indique las vitaminas):_____

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☐ Please list herbal supplements: (Indique suplementos herbales)

Previous Gastroenterology Procedures - Procedimientos de gastroenterología previos

☐ None (Ninguno)

☐ Colonoscopy (Colonoscopia)
☐ EGD - Upper Endoscopy (EGD/Endoscopia Superior)
☐ ERCP
☐ Endoscopic ultrasound/EUS (Ecografia endoscopica/EUS)
☐ Small bowel capsule (Capsula de intestino delgado)
☐ Liver biopsy (Biopsia de Higado)
Other: _____ (Otro)

Surgical Procedures - Procedimientos quirúrgicos

☐ None (Ninguno)

☐ Appendectomy (Apendectomia Coronaria)
☐ C-Section (Cesarea)
☐ Cataract surgery (Cirugia de catarata)
☐ Colon resection (Reseccion de Colon)
☐ Coronary artery bypass (Bypass de arteria)
☐ Coronary/ Stent (Coronario/Stent)
☐ Defibrillator (Desfibrilador)
☐ Gallbladder (Removed) (Extirpación de vesícula)
☐ Gastric bypass (Bypass gastrico)
☐ Heart Valve replacement/repair (Reemplazo/reparación de válvula cardíaca)
☐ Hemorrhoidectomy (Hemorroidectomia)
☐ Hiatal Hernia Surgery (for reflux) (Cirugía de hernia hiatal (por reflujo))
☐ Hysterectomy partial (Ovaries intact) (Histerectomía, parcial (ovarios intactos))
☐ Hysterectomy (Ovaries removed) (Histerectomía, total (extirpación de ovarios))
☐ Inguinal Hernia Surgery (Groin) (Cirugía de hernia inguinal (ingle))
☐ Joint Surgery/ replacement (Cirugia/reemplazo de articulacion)
☐ Lap band (Banda gastrica)
☐ Liver transplant (Trasplante de hígado)
☐ Mastectomy (Mastectomia)
☐ Pacemaker (Marcapasos)
☐ Prostatectomy (Prostatectomia)
☐ Tonsillectomy (Amigdalectomia)
☐ Tubal ligation (Ligadura de trompas)
☐ Ulcer surgery (Cirugia de ulcera)
☐ Umbilical hernia surgery (belly-button) (Hernia umbilical (ombilgo))

Other: _____ (Otro)

Social History- Antecedentes sociales

Occupation: _____ (Ocupación)

Marital Status - Estado civil

☐ Single (Solter)
☐ Married (Casado)
☐ Divorced (Divorcia)
☐ Separated (Separado)
☐ Widowed (Viudo)
☐ Other (Otro)

Alcohol

☐ None (Ninguno)

☐ Less than 7 drinks per week (Menos de 7 tragos por semana)
☐ More than 7 drinks per week (Más de 7 tragos por semana)
☐ I quit using alcohol (Dejé de tomar alcohol)

Tobacco - Tabaco

Smoking Status

☐ Current Every day smoker (Fumador diario)
☐ Current Some Day Smoker (Fumador ocasional actual)
☐ Former smoker (Ex fumador)
☐ Never smoker (Nunca fumó)
☐ Smoker, current status unknown (Fumador, estado actual desconocido)
☐ Light tobacoo smoker (Fumador de tabaco liviano)
☐ Heavy Tobacco Smoker (Fumador de tabaco pesado)
☐ Unknown if ever smoked (Se desconoce si fumó alguna vez)

☐ Cigar (Cigarro)
☐ Chewing tobacco (Masca tabaco)

Drug Use - Consumo de drogas

☐ None (Ninguno)

☐ I have used recreational drug in the past. (Consumí drogas recreativas)
☐ I am currently using recreational drugs. (Consumo actualmente drogas recreativas)
☐ I have been treated for substance abuse. (Me sometí a tratamiento por abuso de sustancias)

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Family Medical History - Antecedentes familiares

☐ No knowledge of family history (Se desconoce el antecedente familiar)

No family history of (No Hay) ☐ Colon cancer (Cancer de) ☐ Polyps (Polipo)

	Mother (Madre)	Father (Padre)	Sister (Hermana)	Brother (Hermano)	Son (Hija)	Daughter(Hijo)	Maternal Grandmother (Abuela materna)	Maternal Grandfather (Abuelo materno)	Paternal Grandmother (Abuela paterna)	Paternal Grandfather (Abuelo paterno)	Maternal Aunt (Tia Materna)	Maternal Uncle (Tio Materno)	Paternal Aunt (Tia Paterna)	Paternal Uncle (Tio Paterno)	Other (otro)
Diagnoses															
Colon Cancer (Cancer de Colon)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colon polyps (Polipos en el Colon)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Crohn's disease/Ulcerative colitis (Enfermedad de Crohn- colitis ulcerosa)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Liver disease (Enfermedad hepática)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Kidney cancer (Cáncer de riñón)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Uterine cancer (Cáncer de útero)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stomach cancer (Cáncer de estómago)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Bladder cancer (Cáncer de vejiga)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pancreatic cancer (Cáncer de páncreas)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ovarian cancer (Cáncer de ovarios)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Review Of Systems - Revisión de sistemas

Gastrointestinal

None (Ninguno) Y N

- abdominal pain (Dolor abdominal)
- anorectal pain/itching (Picazon/dolor anorrectal)
- black tarry stools (Heces alquitranadas)
- bloating/gas (Hinchazon/gases)
- blood in stool (Sangre en heces)
- change in bowel habits (Cambio de hábitos intestinales)
- constipation (Estreñimiento)
- diarrhea (Diarrea)
- stool incontinence(leakage) (Incontinencia de heces)
- hearburn/reflux (Acidez/reflujo)
- difficulty swallowing (Dificultad para tragar)
- nausea (Náuseas)
- Vomiting (Vomitos)

Genitourinary

None(Ninguno) Y N

- blood in urine (Sangre en orina)
- dark urine (Orina oscura)
- enlarged prostate (Próstata agrandada)
- frequent urinary infections heavy (Infecciones urinarias frecuentes)
- menstruation (Menstruación abundante)
- pain/burning with urination (Dolor/ ardor al orinar)
- pregnancy (Embarazo)
- sexually transmitted disease (Enfermedad de transmisión sexual)
- urinary incontinence frequent (Incontinencia urinaria)
- urination (Micción frecuente)

Integumentary (Tegumentario)

None (Ninguno) Y N

- itching (Picazón)
- jaundice (Ictericia)
- rashes (Erupciones)
- suspicious lesions (Lesiones sospechosas)

Cardiovascular

None (Ninguno) Y N

- heart murmur (Soplo cardíaco)
- irregular heart beat (Latido irregular)
- hand/ankle swelling (Hinchazón de manos/tobillos)
- rapid heart rate/palpitations (Latido acelerado/palpitaciones)
- shortness of breath (Falta de aliento)
- chest pain (Dolor en el pecho)

Neurological (Neurológico)

None (Ninguno) Y N

- frequent headaches (Cefaleas frecuentes)
- memory loss/confusion (Pérdida de memoria-confusión)
- numbness or tingling (Adormecimiento u hormigueo)

Endocrine (Endocrino)

None (Ninguno) Y N

- cold intolerance (Intolerancia al frío)
- excessive thirst (Sed excesiva)
- heat intolerance (Intolerancia al calor)

Constitutional (Constitucional)

None (Ninguno) Y N

- chills (Escalofríos)
- fatigue (Fatiga)
- fever (Fiebre)
- loss of appetite (Pérdida de apetito)
- night sweats (Sudoración nocturna)
- weight gain (Aumento de peso)
- weight loss (Pérdida de peso)

Psychiatric (Psiquiátrico)

None (Ninguno) Y N

- anxiety (Ansiedad)
- bipolar disorder (Trastorno bipolar)
- depression (Depresión)

ENMT (OTORRINOLARINGOLOGÍA)

None (Ninguno) Y N

- double vision (Visión doble)
- eye irritation (Irritación ocular)
- eye pain (Dolor ocular)
- eye redness (Enrojecimiento ocular)
- sore throat (Dolor de garganta)
- hoarseness (Ronquera)
- mouth sores (Llagas en la boca)
- nose bleeds (Hemorragias nasales)
- post-nasal drip recurrent sinus infections (Sinusitis recurrentes)

Hematologic/Lymphatic (Hematológico/linfático)

None (Ninguno) Y N

- anemia
- blood transfusions (Transfusiones de sangre)
- easy bruising (Hematomas frecuentes)
- prolonged bleeding (Sangrado prolongado)

Musculoskeletal (Musculoesquelético)

None (Ninguno) Y N

- back pain (Dolor de espalda)
- joint pain (Dolor de articulaciones)

Respiratory (Respiratorio)

None (Ninguno) Y N

- frequent cough (Tos frecuente)
- shortness of breath (Falta de aliento)
- snoring (Ronquido)
- sleep apnea (Apnea de sueño)
- wheezing (Sibilancia)

Allergic/Immunologic (Alérgico/inmunológico)

None (Ninguno) Y N

- allergies (Alergias)
- HIV exposure (Exposición al VIH)
- immune deficiency (Inmunodeficiencia)

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.
(Otorgo consentimiento para obtener el historial de mis medicamentos adquiridos en farmacias.)

Yes (Si) No

Reminder Preference

I would like to receive preventive care and follow up care reminders.
(Me gustaría recibir recordatorios de atención preventiva y de seguimiento.)

Yes (Si) No

Reviewed with

Patient (Paciente) Parent (Padre) Guardian (Tutor) Not Present (No presente)

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Signature - Firma

Signature
(Firma)

Date
(Fecha)