Southern Illinois GI Specialists, LLC

PATIENT REGISTRATION & MEDICAL HISTORY

PATIENT INFORMATION - The person being seen by the doctor **Today's Date**____________

Last Name________________________________ **First**_________________________________ **Initial**_____

Date of Birth_____________ **Social Security #**________________________ **Maiden/Other Name**_____________

Patient Sex: ☐-Male ☐-Female **Preferred Language:** ☐-English ☐-Other________________

Race: ☐-White/Caucasian ☐-African American ☐-Asian ☐-Hispanic/Latino

☐-American Indian/Alaskan Native ☐-Native Hawaiian/Pacific Native ☐-Prefer not to answer

Ethnicity: ☐-Not Latino/Hispanic ☐-Latino/Hispanic ☐-Prefer not to answer

Marital Status: ☐-Single ☐-Married ☐-Civil Union ☐-Divorced ☐-Separated ☐-Widowed ☐-Other

Mailing Address__________________________________ City_________________ State____ Zip_______

Home Address________________________________ City________________ State____ Zip_______

Patient's Occupation___________________________ **Employer**____________________________________

Employer's Address_____________________________ City_____________ State______ Zip_______

Please check the following ways which you may be contacted & list your contact information:

☐ Home Phone__(____)_______-___________ ☐ Cell Phone___(____)_______-_____________

☐ Work Phone__(____)_______-____________ ☐ Email___________________________________

Please circle how you would like to be contacted (circle all that apply):

-OK to leave message with detailed information	Home	Work	Cell	None
-OK to leave call-back number only	Home	Work	Cell	None
-OK to send mail to	Home	Work		None
-OK to fax to	Home	Work		None

GUARANTOR INFORMATION -Person who carries the insurance policy or is responsible for payment.

Primary Insurance_______________________ **ID#**____________________ **Group#**_________________

Patient's Relationship to Policyholder: 1—Self 2—Spouse 3—Child 4—Other:_______________

Guarantor's Last Name__________________________ First________________________ Initial_____

Date of Birth_________________ Social Security Number________________________________

Home Address______________________________ City_________________ State____ Zip_______

Mailing Address______________________________ City________________ State____ Zip_______

☐ Home Phone__(____)_______-___________ ☐ Cell Phone___(____)_______-____________

☐ Work Phone__(____)_______-___________ ☐ Email________________________________

Guarantor's Occupation________________________ Employer__________________________________

Employer's Address______________________________ City____________ State______ Zip_______

Secondary Insurance_____________________ **ID#**____________________ **Group#**_________________

Patient's Relationship to Policyholder: 1—Self 2—Spouse 3—Child 4—Other:_______________

Guarantor's Last Name__________________________ First________________________ Initial_____

Date of Birth_________________ Social Security Number________________________________

☐ Home Phone__(____)_______-___________ ☐ Cell Phone___(____)_______-____________

INFORMATION RELEASE

I authorize release of any medical information necessary to process Medicare and/or any insurance claims. I authorize payment of medical benefits to *Southern Illinois GI Specialists, LLC*. I understand I am responsible for any deductibles, co-payments, coinsurance or amounts not covered by the insurance carrier. In addition, I am aware that if I cannot attend a scheduled appointment I must call at least 24 hours in advance so that we can serve other patients.

X____ ________________

Patient Signature **Date**

CURRENT MEDICAL INFORMATION

Height_____________ **Weight**_____________

Patient's Primary Doctor________________________ **Referring Physician**_______________________

Preferred Pharmacy Name__________________________ **Pharmacy's City**_______________________

Reason for seeing a Gastroenterologist ____

Current Symptoms (check all that apply)

☐-Abdominal Pain	☐-Diarrhea	☐-Blood on toilet paper	☐-Acid reflux
☐-Nausea	☐-Constipation	☐-Change in bowel habits	☐-Belching / burping
☐-Vomiting	☐-Hemorrhoids	☐-Gas / bloating	☐-Indigestion
☐-Bloody vomiting	☐-Anal pain	☐-Heartburn	☐-Jaundice
☐-Fever	☐-Stool incontinence	☐-Lactose intolerance	☐-Abnormal liver tests
☐-Chills	☐-Rectal bleeding	☐-Difficulty swallowing	☐-Anemia
☐-Loss of appetite	☐-Blood in stool	☐-Food sticking in esophagus	☐-Other:_____________
☐-Weight loss	☐-Black, tarry stool	☐-Painful swallowing	☐-None

Allergies to Medicine:

1. Are you allergic to any medications? NO YES—If yes, please name medications & reactions:

____

____

Medications:

1. Do you take aspirin or arthritis medication (ibuprofen, naproxen, Aleve, Motrin, Advil)? NO YES

If yes, please name medication & frequency: ____

____

2. Do you take blood thinners (Coumadin, Warfarin, Heparin, Lovenox, Plavix)? NO YES

If yes, please name medication & frequency:

____

____

3. Please list all other medications you take (including "over-the-counter"), dosage, & frequency taken:

____

____

____

PATIENT MEDICAL HISTORY

Substances

1. Do you use alcohol? NO YES—If yes, please list how much and how often for each:

Beer_______________ Wine_______________ Liquor_____________ Other_________________

2. Do you eat or drink caffeine? NO YES—If yes, please list how much and how often for each:

Coffee_____________ Energy drink/supplement _______________
Cola/Soda_______________ Tea_______________ Chocolate________________

3. Do you / have you ever used tobacco? NO YES—If yes, please complete the following:
Year started_________ Year quit_________ Number of packs/day?__________

4. Have you ever used street drugs? NO YES—If yes, please complete the following:
Type____ and Date of Last Use____________

Diagnostic Studies/Tests

1. Have you had a ☐-Colonoscopy or ☐-Sigmoidoscopy done in the past 10 years? NO YES

If yes, who performed?____________ Year? ______ Anything found?_________________________

2. Have you had an Upper Endoscopy (EGD) done in the past 10 years? NO YES

If yes, who performed?____________ Year? ______ Anything found?_________________________

Previous Surgical History (check all that apply)

- ☐ Removal of appendix
- ☐ Removal of gallbladder
- ☐ Removal of tonsils
- ☐ Total hysterectomy
  - ☐ Removal of uterus ONLY
  - ☐ Removal of ovaries ONLY
- ☐ C-section
- ☐ Tubal Ligation
- ☐ Prostate surgery
- ☐ Lung surgery
- ☐ Bladder suspension
- ☐ Stomach ulcer surgery
- ☐ Colon surgery
- ☐ Hemorrhoidectomy surgery
- ☐ Rectal prolapse
- ☐ Inguinal hernia repair
- ☐ Abdominal hernia repair
- ☐ Hiatal hernia repair
- ☐ Thyroid surgery
- ☐ Gastric bypass surgery
- ☐ Blood transfusions
- ☐ Coronary bypass
- ☐ Heart valve
- ☐ Pacemaker placement
- ☐ Defibrillator (AICD) placement
- ☐ Total knee replacement
- ☐ Total hip replacement

Past or Present Medical Conditions (check all that apply)

- ☐ High Blood Pressure
- ☐ Elevated Cholesterol
- ☐ Heart Attack/MI
- ☐ Heart Disease/Stents
- ☐ Heart Valve Problem/Murmur
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Heart Arrhythmia
- ☐ Pacemaker/Defibrillator
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sleep Apnea
- ☐ Lung Clots
- ☐ Stroke/TIA
- ☐ Seizure Disorder
- ☐ Alzheimer's Disease
- ☐ Parkinson's Disease
- ☐ Thyroid Disease
- ☐ Bleeding Disorder
- ☐ Hemophilia
- ☐ Fibromyalgia
- ☐ Hemodialysis
- ☐ Fatty Liver
- ☐ Liver Cirrhosis
- ☐ Diabetes Mellitus
- ☐ Kidney Problems
- ☐ Hiatal Hernia
- ☐ Stomach/Duodenal Ulcer
- ☐ Celiac Disease
- ☐ Irritable Bowel (IBS)
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ GERD/Acid Reflux
- ☐ Barrett's Esophagus
- ☐ Pancreatitis
- ☐ Helicobacter Pylori
- ☐ Anemia
- ☐ Lupus
- ☐ Valley Fever
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Hepatitis

Please list other medical/surgical history that may not have been listed:

____

____

FAMILY MEDICAL HISTORY

Has anyone in your immediate family been diagnosed with ☐-colon cancer or ☐-polyps? NO YES
If yes, please explain and list how they are related to you________________________________

____

Does anyone in YOUR FAMILY have the following illnesses? Write in the relationship of the family member, i.e. mother, maternal aunt, sister, paternal grandmother. ☐-**No Family History of Cancer**

__________Colon polyps	__________Stomach cancer	__________Liver cancer
__________Colon cancer	__________Esophageal cancer	__________Skin cancer (Melanoma)
__________Celiac disease	__________Small bowel cancer	__________Uterine/cervical cancer
__________Crohn's disease	__________Pancreatic cancer	__________Gallbladder disease
__________Ulcerative colitis	__________Rectal cancer	__________Gallbladder cancer

SUPPORT PERSONS - Please provide phone numbers other than your home.

Emergency Contact

Name____________________ Relationship________________ Birthday_______ Phone#______________

Do you have an advanced directive for Healthcare (living will or medical Power of Attorney)? NO YES

If yes, we are required to have a copy on file.

Those who may receive information regarding me:

Name____________________ Relationship________________ Birthday_______ Phone#______________

Name____________________ Relationship________________ Birthday_______ Phone#______________

Name____________________ Relationship________________ Birthday_______ Phone#______________

CORRECTNESS OF INFORMATION

I certify that the all of the information I have provided on this form is correct to the best of my knowledge. I will not hold my doctor or any member of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.

X____

Patient Signature **Date**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that the office's Notice of Privacy Practices has been made available to me. (Original document to be kept in patient's permanent medical record.)

☐ I have received information regarding the provider(s) of care in this organization.*

☐ I have received information regarding the grievance process.* *Available in waiting area.

X____

Patient or legally authorized individual signature **Date**

____ ____

Printed Name if signed on behalf of the patient **Relationship (legal guardian, personal rep., etc.)**

NOTIFICATION OF OUTPATIENT PRACTICE

I understand that through Southern Illinois GI Specialists, LLC, Dr. Zahoor A. Makhdoom has established an outpatient practice. I understand that if I were to be hospitalized for any digestive related issues (not including issues relating to procedures performed by Dr. Zahoor A. Makhdoom directly) I will be seen by the physician on call at that particular hospital and not Dr. Zahoor A. Makhdoom.

X____

Patient Signature **Date**