Gwinnett Digestive Clinic PC

Indran B. Krishnan, M.D.

Gastroenterology New Patient Form

1) Patient's name: ______________________________ Age: ________ Date of Birth: ____________

2) Referring physician: ______________________ Primary care physician: ______________________

3) Problem or reason for your visit: ____

____

4) **Medical History:** (Please circle ALL the medical Diseases/illnesses:)

- ☐ Diabetes Mellitus
- ☐ Obesity
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Disease
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Diverticulosis
- ☐ Hemorrhoids
- ☐ Liver Disease
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Dyspepsia
- ☐ Dysphagia
- ☐ Esophageal Stricture
- ☐ Gastritis
- ☐ Heartburn
- ☐ Gas
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Lactose Intolerance
- ☐ Peptic Ulcer Disease
- ☐ GERD
- ☐ Anal Fissure
- ☐ Other: ________

5) **Hospitalizations & Surgeries:** ____

____

____

6) **Please circle the following if they have been performed:**

	Labs	X-rays	CT scan	Barium	Ultrasound	Endoscopy	Colonoscopy
Dates:	________	________	________	________	________	________	________

7) **Allergies:** *(List all allergies to drugs, medicines, latex, bee sting, etc. and give reaction)*

____

8) **Medications:** *(Please see the separate form)*

9) **Social History:** **(Please provide details regarding current and past use of the following - estimate daily or weekly usage)**

Tobacco (Cigarettes, Cigars, Chewing Tobacco): ____________________________________

Alcohol: ❑None ❑Beer ❑Wine ❑Liquor.

How often (# drinks per day or week, on average): ______________________________

I.V Drug Use / Recreational Drugs: ❑ Yes ❑ No.

10) **Family History:** *(Please include which family member and age of diagnosis if known)*

	Mother	Father	Siblings	Grandparents	Others
Colon cancer					
Colon polyp					
Ulcerative colitis					
Crohn's disease					
Celiac disease					
Other GI cancer					
Liver disease					
Diabetes mellitus					
Heart disease					
Other					

Systems Review *(Do you have or have you recently experienced any of the following?)*

EARS, EYES, NOSE, MOUTH, THROAT
- ❑ Mouth Ulcers/Sores
- ❑ Sore throat

SKIN
- ❑ Rash
- ❑ Itching
- ❑ Psoriasis

DIGESTIVE SYSTEM
- ❑ Difficulty in Swallowing, ❑ Solids or ❑ Liquids
- ❑ Abdominal Pain
- ❑ Black Tarry Stools
- ❑ Diarrhea
- ❑ Change in bowel habits
- ❑ Colon Polyps
- ❑ Constipation
- ❑ Crohn's disease
- ❑ Bloating/Belching/Gaseousness
- ❑ Dysphagia
- ❑ Food intolerance
- ❑ Gall stones
- ❑ Gas
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernias
- ❑ Indigestion
- ❑ Irritable Bowel Syndrome
- ❑ Jaundice
- ❑ Liver disease
- ❑ Nausea
- ❑ Poor Appetite
- ❑ Rectal bleeding
- ❑ Regurgitation
- ❑ Ulcerative colitis
- ❑ Vomiting

PSYCHIATRIC
- ❑ Depression/Anxiety
- ❑ Past Evaluation/Treatment

ALLERGY/IMMUNOLOGY
- ❑ HIV/AIDS
- ❑ Blood Transfusion

RESPIRATORY
- ❑ Shortness of breath
- ❑ Asthma/Wheezing/Cough

CARDIAC
- ❑ Chest Pain
- ❑ Palpitation
- ❑ Irregular heartbeat
- ❑ Pacemaker
- ❑ Hypertension
- ❑ History of Heart attack

GENITOURINARY
- ❑ Are you pregnant?
  Date of last period? ____________
- ❑ Difficulty with urination
- ❑ History of Kidney stone

MUSCULOSKELETAL
- ❑ Joint pain/arthritis
- ❑ Back Pain
- ❑ Problems Walking
- ❑ Lupus, Scleroderma or related disease

NEUROLOGIC
- ❑ Headache
- ❑ Seizure disorder
- ❑ stroke

HEMATOLOGIC
- ❑ Easy bruising/bleeding
- ❑ Anemia

ENDOCRINE
- ❑ Diabetes
- ❑ Thyroid Disease

Gwinnett Digestive Clinic PC

PATIENT DATA SHEET- MUST BE COMPLETED IN FULL

Patient Name: ______________________________

Patient's S.S.# ______________ **Date of Birth:** ____________ **Sex.** ________

Home Address: ______________________________
(Street) (Apt #)

____
(City) (State) (Zip)

Home Phone: ______________ **Work Phone:** ______________
Cell Phone: ______________ **Profession/Work:** ______________
Patient's Employer: ______________ **Calls ok at work?** ________
Employer's Address: ______________________________

Details of Insured (If different from patient)
Name of Insured: ______________ **S.S.#:** ______________
Relationship to Patient: ______________ **Employer:** ______________
Date of Birth: ______________ **Employer's Address:** ______________
Home Phone: ______________ **City, State, Zip:** ______________
Work Phone: ______________ **Calls ok at work?** ______________

EMERGENCY CONTACT: Nearest relative/ Friend NOT living with you
Name: ______________ **Phone:** ______________

PLEASE INDICATE PRIMARY & SECONDARY INSURANCE AND PERMIT US TO MAKE COPIES OF YOUR INSURANCE CARDS:
Primary Ins: ______________ **Name of Insured:** ______________

Secondary Ins: ______________ **Name of Insured:** ______________

PLEASE READ CAREFULLY THE FOLLOWING INFORMATION:
IN ORDER TO CONTROL THE COST OF HEALTHCARE, WE REQUEST THAT YOU PAY YOUR DEDUCTIBLE, CO-INSURANCE, AND ANY PREVIOUS BALANCE AT THE TIME OF THE VISIT.

PATIENT'S (OR GUARDIAN/ INSURED) AFFIDAVIT, ASSIGNMENT AND RELEASE STATEMENT:
I/we certify that the above information is true & authorize payment of medical benefits to Gwinnett Digestive Clinic PC (Clinic) and authorize them to release any medical information necessary to process claims. I/we am/are totally responsible for co-payments, deductibles, and non-covered services.
In the event the account becomes overdue or delinquent, the clinic shall be entitled to reimbursement from me/us for clinic's reasonable expenses of the collection including attorney/legal fees. Clinic may charge me of 1.5% per month or the highest lawful monthly contract rate on overdue account.

SIGNATURE ______________________________ **DATE** ______________
(PATIENT/GUARDIAN/INSURED)

Gwinnett Digestive Clinic, PC

NOTICE OF PRIVACY PRACTICES POLICY

I have been given an opportunity to review a copy of *Gwinnett Digestive Clinic's* Notice of Privacy Practices. I consent to the uses and disclosures of my health information as outlined in the notice.

______________________________	______________________________
Signature of Patient/ Representative	Date
______________________________	______________________________
Print Name of Patient	Print Name of Representative

Please describe the Representative's authority to act on behalf of Patient (check one):

(   ) The parent of the minor patient

(   ) The legal guardian of the patient, who has been adjudicated incompetent.

(   ) Durable Power of Attorney for Health Care for the patient and has given a proof of the same to *Gwinnett Digestive Clinic* staff.

FOR *Gwinnett Digestive Clinic* USE ONLY

If acknowledgment of receipt of the above is not obtained from the patient/ representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it:

____

____

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____

____

____

Gwinnett Digestive Clinic
Medication Reconciliation Form

Patient Name: ______________________________ **Chart #:** ______________

DOB: ______________ **Medications Verified on:** ______________

Medication	Dose	Frequency	Route

Drug Allergies: ____

Medications Verified by: ____

Gwinnett Digestive Clinic PC
Indran Krishnan MD

Patient Name:
DOB:
Date:

Reflux/Heart Burn & Esophageal Cancer

Recent medical studies have proven that frequent heartburn may pose a greater risk for cancer of the esophagus. Take this short test to assess your own risk!

Definitions:

Heartburn – a burning or acid feeling in the chest located behind the breastbone. Also called "indigestion". "**Reflux/Regurgitation** – When food or "hot water" comes up in the back of the throat. A bitter / acid feeling in the back of the throat.

Instructions:

Place your score for each question in the box. Add your total score.
Compare your score to the ***"esophageal cancer risk scale".***

	Your Score
Question 1	
I have heartburn (yes = 1; no = 0)	____
I have reflux (yes = 1; no = 0)	____
I have both heartburn and reflux (yes = 1; no = 0)	____
Question 2	
I have heartburn or reflux at night (yes = 1; no = 0)	____
Question 3	
Frequency of heartburn or reflux (1 answer only):	
Once a week (yes = 0)	____
2-6 times a week (yes = 1)	____
7-15 times a week (yes = 2)	____
More than 15 times a week (yes = 3)	____
Add the total for your score:	____

ESOPHAGEAL CANCER RISK

Your score: ________

If your score is:	*Your cancer risk is:*
1–2	1.4 times the normal risk
2.5 - 4	8 times the normal risk
Greater than 4	20 times the normal risk

If your risk is greater than normal, please discuss your symptoms with your doctor for further evaluation.