Shahram Javaheri, M.D.
Gastroenterology, Hepatology & Obesity Medicine

Mission Viejo Office
26691 Plaza Drive Suite 150
Mission Viejo, CA 92691

www.MyBellyDoctor.com
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Office (949) 389-0660 Fax (949) 389-0668

PATIENT MEDICAL HISTORY FORM

Name: _____Age: _____ Date of Birth: _____ Date of Visit:_____

Reason for Consultation:_____

PAST MEDICAL HISTORY: *(Check Box and / or Add additional to bottom)*

□ None
□ Acid Reflux (GERD)
□ Anemia
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Barrett's Esophagus
□ Bleeding Disorder
□ Blood Clots:
  □ Lungs (PE)
  □ Deep Vein (DVT)
□ Blood Transfusion
□ Bronchitis
□ Cancer: type_____
□ Celiac Disease
□ Chest Pain/Angina
□ Chronic Anxiety
□ Chronic Sinusitis
□ Cirrhosis of the Liver
□ Colitis
□ Colon Cancer
□ Colon Polyps
□ COPD
□ Coronary Artery Disease
□ Crohn's Disease
□ Depression
□ Dementia
□ Diabetes: type: I II
□ Diverticulosis
□ Diverticulitis
□ Duodenal Ulcer
□ Eating Disorder _____
□ Emphysema
□ Fatty Liver Disease
□ Gallstones
□ Glaucoma
□ Gout
□ Groin Hernia
□ Heart Attack
□ Heart Failure (CHF)
□ Heart Murmur
□ Hemorrhoids
□ Hepatitis: type
□ Hiatal Hernia
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Irritable Bowel Syndrome
□ Kidney Disease
□ Kidney Failure
□ Kidney Stones
□ Lupus
□ Migraines
□ Milk Intolerance
□ Multiple Sclerosis
□ Osteoporosis
□ Ovarian Cyst
□ Pancreatitis
□ Parkinson's disease
□ Peptic Ulcer
□ Pneumonia
□ Polio
□ Psoriasis
□ Radiation Therapy
□ Rheumatic Fever
□ Seizures
□ Sleep Apnea- use CPAP machine?_____
□ Stomach Ulcer
□ Stroke or Paralysis
□ Substance Abuse:
  □ Alcohol
  □ Methamphetamine
  □ Marijuana
  □ IV Drugs
  □ Opiates/Cocaine
□ TB (Tuberculosis)
□ Thyroid Disorder:
  □ Hypothyroidism
  □Hyperthyroidism
□ Ulcerative Colitis
□ Vascular Disease
□ Other:
_____
_____
_____
_____

PAST SURGERIES/PROCEDURES *(Check Box and / or Add additional to bottom)*

□ None
□ Abdominoplasty
□ Aortic Aneurysm Repair
□ Appendectomy
□ Back Surgery
□ Colonoscopy
□ Colon Resection
□ C-Section: _____(#)
□ Defibrillator Placement
□ EGD
□ Gallbladder Removal
□ Hernia:
  □Groin (Left or Right)
  □Umbilical
□ Heart Bypass (CABG)
□ Heart Stent/Cardiac Cath
□ Heart Valve Replacement
□ Hemorrhoid Banding
□ Hemorrhoidectomy
□ Hiatal Hernia Repair
□ Hysterectomy
□ Joint Replacement:
Which joint? _____
□ Kidney Surgery
□ Liver Biopsy
□ Mastectomy
□ Obesity Surgery
  □Gastric Lap Band
  □Gastric Sleeve
  □Gastric Bypass
□ Ovary Removed
□ Pacemaker Placement
□ Prostate Removed
□ Sigmoidoscopy
□ Small Bowel Resection
□ Thyroid
□ Tonsillectomy
□ Tubal Ligation
□ Other:
_____
_____
_____

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SOCIAL HISTORY

Children: □ None □Yes: (#) _____
Smoking History: □ Never □ Yes: _____ Packs per day for _____ Years
Smoking History □ Never □ Former Smoker Quit date: _____ □ Current Daily Smoker □ Current Occasional Smoker
Alcohol Use: □ No □ Yes: amount per day_____ for _____Years
Recreational Drug Use: □ No □ Yes: Specify drug and amount: _____
Recent Travel outside US: □ No □ Yes; Where: _____
Exercise: □ None □ Occasionally □ Daily

REVIEW OF SYSTEMS: (check all that apply at the present time)

General
□ Fever or chills
□ Loss of appetite
□ Weight loss
□ Weight gain
□ Weakness or fatigue

Gastrointestinal
□ Abdominal distention/Bloating
□ Abdominal pain
□ Belching
□ Black stools
□ Blood noted in stool sample
□ Change in bowel habits/stool caliber
□ Constipation
□ Diarrhea
□ Difficulty Swallowing
□ Fatty food intolerance
□ Full after eating small amounts
□ Gas/bloating
□ Heartburn/GERD (acid reflux)
□ Indigestion
□ Hemorrhoids
□ Jaundice
□ Nausea only
□ Nausea and Vomiting
□ Painful swallowing
□ Rectal bleeding
□ Rectal pain
□ Regurgitation of food
□ Soiling /Fecal incontinence
□ Vomiting blood

Cardiovascular
□ Chest pain or tightness
□ Rapid or irregular heart rate
□ Swelling of the legs

Eyes, Ears, Nose,Throat
□ Wear glasses/contacts
□ Double vision
□ Blurred vision
□ Loss of vision
□ Ear pain
□ Sore throat
□ Hoarseness of Voice
□ Hearing difficulty
□ Deafness
□ Ringing in Ears
□ Dentures

Respiratory
□ Chronic cough
□ Wheezing
□ Shortness of Breath

Urinary
□ Painful urination
□ Difficulty with urination
□ Frequent urination
□ Blood in urine

Musculoskeletal
□ Stiff or Painful joints
□ Swollen joints
□ Back pain
□ Muscle pain

Hematologic
□ Frequent bruising
□ Bleeding doesn't stop easily

Endocrine
□ Heat or cold intolerance
□ Excessive thirst

Genitoreproductive – male
□ Discharge from penis
□ Testicular lump or pain

Genitoreproductive – female
□ Heavy periods

Dermatologic
□ Rash or Hives
□ Itching
□ Loss of hair
□ Tattoos

Neurologic
□ Numbness or tingling
□ Lightheadedness
□ Vertigo (Dizziness)
□ Headaches
□ Difficulty with Memory/Dementia
□ Confusion

Psychiatric
□ Anxiety
□ Depression
□ Panic Attacks
□ Bipolar Disorder
□ Psychosis

Immunizations
□ Hepatitis A □ Hepatitis B

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PATIENT INFORMATION FORM

FIRST NAME_____MIDDLE INITIAL_____ LAST NAME_____

GENDER: F M SSN:_____ MARITAL STATUS: S M W D OTHER

BIRTH DATE: _____ RACE:_____(SPECIFY OR DECLINE)

ETHNIC GROUP (CIRCLE): HISP NON-HISP DECLINE E-MAIL_____

ADDRESS: _____CITY: _____

STATE: _____ZIP:_____DRIVER'S LICENSE#_____

HOME#: _____CELL#:_____WORK#: _____

REFERRED BY: _____PRIMARY CARE DOCTOR: _____

EMPLOYER: _____OCCUPATION:_____

ADDRESS: _____CITY: _____ STATE:_____ ZIP:_____

SPOUSE/NEAREST RELATIVE: _____PHONE:_____

SPOUSE'S EMPLOYER: _____BIRTHDATE:_____SSN_____

EMERGENCY CONTACT: _____RELATION/PHONE: _____

PRIMARY INSURANCE

COMPANY: _____

ID#:_____

GROUP#:_____

INSURED: _____

CO-PAY:_____

SECONDARY INSURANCE

COMPANY: _____

ID#:_____

GROUP#:_____

INSURED: _____

CO-PAY:_____

I guarantee payment to Shahram Javaheri, MD. I authorize my insurance company(ies) to pay any and all charges rendered on my behalf to Shahram Javaheri, MD. I will be responsible for and will guarantee on any and all charges, which may not be paid or covered by my insurance company(ies), including but not limited to: co-pay, deductible, and coinsurance. I certify that the information given, including insurance coverage is complete and correct. I understand that payment in full may be required at the time of service. I understand that payment in full is my responsibility regardless of insurance coverage. I understand if my account is submitted for collection I will be charged a 30% fee of the balance that is transferred to the collection agency.

Signature: _____ Date: _____

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PATIENT RECORD DISCLOSURES

I wish to be contacted in the following manner (check all that apply)

Home Phone: ____

Cell Phone: ____

____Ok to leave message with family and/or on machine

____Leave message with call-back number only

Work Phone____

____Ok to leave detailed message

____Leave message with call-back number only

Written Communication

____Ok to mail to home address

____Ok to Fax to (_____) _____

____Ok to Email

I authorize your office to disclose my health information to following people if needed. (We are already authorized to speak to your referring physician)

1) _____ Relationship: _____

2) _____ Relationship: _____

_____ _____
Patient Signature Date

_____ _____
Print Name Date

MEDICATIONS NAME DOSE FREQUENCY

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PHARMACY NAME: _____CITY:_____PHONE NUMBER: (____)_____

MEDICATION ALLERGY & REACTIONS

□ No known drug allergies
□ Codeine □ Penicillin □ Adhesive Tape □ IV Dye Iodine □ Latex Gloves
□ Sulfa □ Other:_____

IMMUNIZATIONS

□ None
□ Flu Vaccine Date:_____ □ Hep A Date:_____ □ Hep B Date:_____ □ Pneuvax Date:_____ □ TB Skin Test Date:_____

FAMILY HISTORY

□ No knowledge of Family History

Family History of the following:

□ Colon Cancer □ Stomach Cancer □ Liver Cancer
□ Esophageal Cancer □ Uterine Cancer □ Pancreatic Cancer
□ Lynch Syndrome □ Breast Cancer (BRCA +) □ Colon Polyps
□ Ulcerative Colitis □ Crohn's Disease

	Father	Mother	Grandparents	Siblings	Other:_____
Colon Cancer	□	□	□	□	□
Colon Polyps	□	□	□	□	□
Liver Cancer	□	□	□	□	□
Esophageal Cancer	□	□	□	□	□
Stomach Cancer	□	□	□	□	□
Pancreatic Cancer	□	□	□	□	□
Uterine Cancer	□	□	□	□	□
Lynch Syndrome	□	□	□	□	□