Digestive Care Associates

1000 Laurel Street
San Carlos, CA 94070
Phone: 650-596-8800
Fax: 650-596-8802

Patient Interview Form

Patient Information

First Name:______________________ Last Name:______________________
MRN:______________________ Date Of Birth:______________________
Age:______________________ Notes:______________________

Race

- ○ White/Caucasian
- ○ Black or African American
- ○ Asian
- ○ Hispanic or Latino
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ Mixed
- ○ Other
- ○ Unknown
- ○ Patient declines to provide information

Ethnicity

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Patient declines to provide information
- ○ Chinese
- Other:__________

Gender

- ○ Male
- ○ Female
- ○ Other

Preferred Language

- ○ English
- ○ Spanish
- ○ Mandarin
- Other:__________

Contact Preference

- ○ Letter
- ● Telephone call
- Other:__________

Allergies

- ○ Patient has no known allergies
- ○ Patient has no known drug allergies

- ○ Penicillins
- ○ Demerol
- ○ Valium
- ○ Adhesive Tape
- ○ codeine sulfate
- ○ latex
- ○ aspirin
- ○ midazolam
- ○ fentanyl
- ○ Sulfa (Sulfonamide Antibiotics)

Current Medications

- ○ None

Name	Dose	How taken?

Diagnostic Studies/Tests

- None
- Colonoscopy — When:______
- Endoscopy — When:______
- Sigmoidoscopy — When:______

Past or Present Medical Conditions

- None
- Anemia — When:______
- Asthma — When:______
- Crohn's Disease — When:______
- Cirrhosis — When:______
- Colon cancer — When:______
- Colon polyps — When:______
- Congestive Heart Failure — When:______
- Diabetes Mellitus — When:______
- GERD — When:______
- Gout — When:______
- Hepatitis — When:______
- Hyperlipidemia — When:______
- Hypertension — When:______
- Other(s) — When:______

Previous Procedures

- None
- Angioplasty — When:______
- Appendectomy — When:______
- Arthroscopy — When:______
- Back Surgery — When:______
- Cardiac Surgery — When:______
- Gallbladder removed — When:______
- Hemicolectomy — When:______
- Hemorrhoidal Banding — When:______
- Hip Replacement (Left) — When:______
- Hysterectomy — When:______
- Laminectomy — When:______
- Mastectomy — When:______
- Tonsillectomy — When:______
- Other(s) — When:______

Social History

Occupation:______ Number of Children:______

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Civil Union
- Unknown
- Other

Alcohol

- None

Type	Quantity	Number	Frequency
Beer			
Vodka			
Wine			
Rum			
Tequila			
Other			

Caffeine

- None
- Coffee
- Tea
- Soda
- Energy Drinks
- Chocolate

Tobacco

Smoking Status

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Unknown if ever smoked

Drug Use

- None

Type	Quantity	Frequency
Marijuana		
Cocaine		
Methampetamine		
IV Drugs		

Exercise

- None

Type	Quantity	Frequency
Running		
Walking		
Swimming		
Biking		
Free Weights		

Family Medical History

- No knowledge of family history

No family history of Colon cancer Polyps

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Health Status	O	O	O	O	O	O
Deceased/At Age	O	O	O	O	O	O
Family history of colon cancer	O	O	O	O	O	O
Family history of colon polyps						

Pharmacy

Name:______________________________

Doctors you want copies of your reports sent to:

Review Of Systems

Constitutional Yes No
- None
- fatigue
- fever
- loss of appetite
- nightsweats
- weight gain
- weight loss

Integumentary Yes No
- None
- dryness
- hives
- itching
- rashes
- suspicious lesions
- Jaundice
- Nodules

Eyes Yes No
- None
- double vision
- loss of vision
- Inflammation

ENMT Yes No
- None
- difficulty swallowing
- dizziness
- ear pain
- hoarseness
- nose bleeds
- sore throat
- Hearing loss
- Mouth sores
- Bleeding gums
- Chronic sinus
- Ringing in ear

Cardiovascular Yes No
- None
- chest pain
- irregular heart beat
- palpitations
- syncope

Respiratory Yes No
- None
- asthma
- cough
- shortness of breath
- wheezing
- Cough up blood

Gastrointestinal Yes No
- None
- abdominal pain
- abdominal distention
- bloating
- change in bowel habits
- constipation
- diarrhea
- difficulty swallowing
- gas
- heartburn
- jaundice
- nausea
- painful swallowing
- rectal bleeding
- stomach cramps
- vomiting
- Blood in stool
- Milk intolerance
- Hemorrhoids

Genitourinary Yes No
- None
- dark urine
- decrease in urine flow
- frequent urinary infections
- frequent urination
- impotence
- urethral discharge or incontinence
- Testicle problem
- Heavy periods

Musculoskeletal Yes No
- None
- arthritis
- back pain
- gout
- joint deformity
- joint pain
- muscle weakness

Endocrine Yes No
- None
- excessive thirst
- hair loss
- heat intolerance

Hematologic/Lymphatic Yes No
- None
- bleeding gums
- easy bruising
- prolonged bleeding
- Enlarged glands

Allergic/Immunologic Yes No
- None
- HIV exposure
- persistent infections
- strong allergic reactions or urticaria

Neurological Yes No
- None
- frequent headaches
- migraine
- numbness or tingling
- seizures
- tremors
- vertigo
- Weakness in arms
- Weakness in legs

Psychiatric Yes No
- None
- anxiety
- depression
- difficulty sleeping
- hallucinations
- panic attacks
- paranoia
- suicidal ideation
- Abnormal sleep
- Memory loss/confusion

I have received, **upon request**, from Digestive Care Medical Center, a Notice of Privacy Practice for Health Information **OR** I understand my privacy rights and do not wish to receive a copy.

______________________ ____________
Signature Date

______________________ ____________
Name of Patient Date of Birth

______________________ ____________
Parent/Guardian (if under age18) Date

____
Social Security Number

____
Mailing Address

____
City, State, Zip Code

____
E-Mail Address (For the purpose of future participation in on-site research study **only**. If you are interested and qualify for such)
We will not give or sell this information to any other parties.

I hereby authorize Digestive Care Medical Center and its' agents to leave any messages regarding my medical condition at the following phone number(s):

(_____) ________________ Home Mobile Office

(_____) ________________ Home Mobile Office

I designate the following family member(s) to whom my protected health information may be disclosed. I understand that I am not required to list anyone and may revoke this request at any time in writing.

Name ________________ Relationship ________

Name ________________ Relationship ________

______________________ (___)____________
Emergency Contact Phone Number

Digestive Care Associates
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(650) 596-8800 fax (650) 596-8802

Financial Policy

We want our patients to be informed about our billing process. As a courtesy, we bill your insurance company for you. If you are scheduled for a procedure, such as a Colonoscopy, Upper Endoscopy, or Hemorrhoid Banding it may result in a bill from our office, Digestive Care Medical Center (our facility), and possibly a pathologist. You are responsible for any co-pays, coinsurance, deductible, and/or any other balance not paid by your insurance within our contracted rates. Please be aware there may be different benefits that apply for wellness, or screening, and for a medically necessary procedure (e.g. removal of polyps, dilating an area, etc.). You may be referred for a screening procedure, but once a polypectomy, biopsy or dilation is performed, it is no longer considered a screening procedure. Insurance coverage is a contract between you and your insurance company. We are not a party to this contract in most cases. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, etc., other than to supply factual information as necessary. Although we make every effort to check benefits in advance, you are responsible to know what your basic benefits are. If you are unsure, the customer service department of your insurance company can help you. Also, please be aware that there is a $300 fee for canceling your procedure within five business days.

Please note that Digestive Care Medical Center does require a deposit of $300.00 for any procedures that are scheduled for Self-Pay patients. The remainder of the balance is due at the time of procedure, unless payment arrangements have been made in advance.

Following a payment from your insurance company, we attempt to bill you monthly for three months. If we have not heard from you after these three months, your account will be considered delinquent and will be turned over to our collection agency.

I consent to necessary medical care and treatment by Scott Levenson, M.D. or Roger Kao, M.D.. I directly assign all medical benefits to Scott Levenson, M.D. or Roger Kao, M.D., and understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

______________________________ ______________

Signature Date

____

Print name