

Medical History

Name: _____ Age: _____ Date of Birth: _____ Date of Visit: _____

Reason for Consult: _____

Medications: *(please list all of your current prescription and non-prescription medications, vitamins and supplements)*

Drug Allergies? No If Yes to what? _____

Past Medical History: *(Check Box and / or Add additional to bottom)*

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Dementia | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes: type: I II | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> I.B.S. | <input type="checkbox"/> Sleep Apnea- use CPAP machine? _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Duodenal Ulcer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Barrett's Esophagus | <input type="checkbox"/> Eating Disorder _____ | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Stroke or Paralysis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Fatty Liver | <input type="checkbox"/> Lupus | <input type="checkbox"/> TB (Tuberculosis) |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer: type _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Milk Intolerance | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chronic Anxiety | <input type="checkbox"/> Groin Hernia | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ovarian Cyst | _____ |
| <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pancreatitis | _____ |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Parkinson's disease | _____ |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Peptic Ulcer | _____ |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Hepatitis: type _____ | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psoriasis | |

Past Surgeries / Procedures: *(Check Box and / or Add additional to bottom)*

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Kidney Surgery | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Heart Valve | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Obesity Surgery | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> C-Section: _____ (#) | <input type="checkbox"/> Hiatal Hernia Repair | <input type="checkbox"/> Ovary Removed | _____ |
| <input type="checkbox"/> EGD | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Prostate Removed | _____ |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Joint Replacement:
Which joint? _____ | <input type="checkbox"/> Sigmoidoscopy | _____ |
| <input type="checkbox"/> Hernia | | <input type="checkbox"/> Stomach | |

Family History: (Check all that apply)

None: _____

Unknown: _____

Adopted: _____

	Father	Mother	Grandparents	Siblings	Other: _____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Diseases: (Example: heart disease, cancer)					

Social History:

- Children:** None Yes: (#) _____
Smoking History: Never Yes: _____ Packs per day for _____ Years
Smoking Now? No Yes If no, quit date?: _____
Alcohol Use: No Yes: amount per day _____ for _____ Years
Drug Use: No Yes: Specify drug and amount: _____
Recent Travel outside US: No Yes; Where: _____

Review of System: (check all that apply at the present time)

- | | | |
|---|---|--|
| <p><u>General</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever or chills <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Weakness or fatigue <p><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal distention <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Abdominal cramping <input type="checkbox"/> Belching <input type="checkbox"/> Black stool <input type="checkbox"/> Blood in stool <input type="checkbox"/> Change in bowel habit <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Fat intolerance <input type="checkbox"/> Full after eating small amounts <input type="checkbox"/> Gas/bloating <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Jaundice <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Pain after swallowing | <ul style="list-style-type: none"> <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Rectal pain <input type="checkbox"/> Regurgitation of food <input type="checkbox"/> Soiling / incontinence <input type="checkbox"/> Vomiting blood <p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain or tightness <input type="checkbox"/> Rapid or irregular heart rate <input type="checkbox"/> Swelling of the legs <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <p><u>Urinary</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain or difficulty urinating <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <p><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Stiff or Painful joints <input type="checkbox"/> Swollen joints <input type="checkbox"/> Back pain <input type="checkbox"/> Muscle pain <p><u>Hematologic</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent bruising <input type="checkbox"/> Bleeding doesn't stop easily <p><u>Endocrine</u></p> | <ul style="list-style-type: none"> <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Excessive thirst or urination <p><u>Genitroreproductive – male</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Discharge from penis <input type="checkbox"/> Testicular lump or pain <p><u>Genitroreproductive – female</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Heavy periods <p><u>Dermatologic</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Rash or Hives <input type="checkbox"/> Itching <input type="checkbox"/> Tattoos <p><u>Neurologic</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> Dizziness or lightheadedness <input type="checkbox"/> Vertigo <input type="checkbox"/> Headaches <input type="checkbox"/> Blurred vision <input type="checkbox"/> Difficulty with Memory <p><u>Psychiatric</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Panic Attacks <p><u>Immunizations</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B |
|---|---|--|

Pacific Coast Digestive Health
Shahram Javaheri, M.D.
26921 Crown Valley Parkway, Suite 201 Mission Viejo, CA 92691

PATIENT INFORMATION FORM

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME#: _____ WK#: _____ CELL#: _____

BIRTH DATE: _____ SS#: _____ LIC# _____

AGE: _____ SEX: F M E-MAIL _____ MARITAL STATUS: S M W D OTHER

REFERRED BY: _____ FAMILY DOCTOR: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSE/NEAREST RELATIVE: _____ PHONE: _____

SPOUSES EMPLOYER: _____ BIRTHDATE: _____ SS# _____

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 (_____) _____

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