Digestive Health Services, S.C.
Phone: (630) 434-9312
Fax: (630) 434-9360

DHS

Rockford G. Yapp, M.D., M.P.H
James R. Clark, M.D.
Anshuman Chawla, M.D.
Lesley K. Dawravoo, M.D.

PATIENT INFORMATION

Last Name:	**First Name:**	**Middle:**	**Date of Birth:**
Gender:	**SSN:**	**Race:**	**Marital Status:**
Address Line:	**City:**	**State:**	**Zip Code:**
Primary Phone:		**Email Address:**	
Alternate Phone:		**Primary Care Physician:**	

EMERGENCY CONTACT INFORMATION

First Name:	**Middle:**	**Last Name:**	**Address Line:**
City:	**State:**	**Zip Code:**	**Home Phone:**	**Relationship:**

PRIMARY INSURANCE INFORMATION

Insurance Name:	**Policy Number:**		**Group Number:**
Subscriber:	**Relationship:**	**Date of Birth:**	**SSN:**

SECONDARY INSURANCE INFORMATION

Insurance Name:	**Policy Number:**		**Group Number:**
Subscriber:	**Relationship:**	**Date of Birth:**	**SSN:**

PHARMACY INFORMATION

Pharmacy Name:	**Address:**	**Phone Number:**

RELEASE OF INFORMATION

Due to HIPAA Regulations we are unable to give information such as biopsy and lab results to anyone not listed on this form. Please list the following people you give consent for your information to be given to:

NAME	RELATIONSHIP

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How were you referred to us? _____

Gastrointestinal Symptoms:

Please check all that apply.

- ☐Heartburn
- ☐Regurgitation
- ☐Trouble swallowing
- ☐Loss of appetite
- ☐Nausea
- ☐Vomiting
- ☐Yellow eyes / jaundice
- ☐Abdominal pain
- ☐Pain after meals
- ☐Bloating
- ☐Diarrhea
- ☐Constipation
- ☐Black / tarry stools
- ☐Rectal bleeding
- ☐Rectal Pain
- ☐Stool incontinence
- ☐Change in bowel habits

Past Medical History:

Please check all that apply, past or present.

- ☐Anemia
- ☐Ulcers
- ☐Colon cancer
- ☐Colon Polyps
- ☐Diverticulitis
- ☐Diverticulosis
- ☐Crohn's disease
- ☐Ulcerative colitis
- ☐Hepatitis B
- ☐Hepatitis C
- ☐Cirrhosis
- ☐GERD
- ☐IBS
- ☐Gallstones
- ☐Pancreatitis
- ☐End Stage Renal Disease
- ☐Heart disease
- ☐Heart murmur
- ☐Hiatal hernia
- ☐High blood pressure
- ☐High cholesterol
- ☐Diabetes
- ☐Stroke
- ☐Seizures
- ☐Cancer
- ☐Emphysema / COPD
- ☐Tattoos
- ☐IV drug use
- ☐HIV (AIDS)
- ☐Blood transfusion
- ☐Arthritis
- ☐Asthma
- ☐Depression
- ☐Kidney stones
- ☐Prostate problems
- ☐Thyroid problems
- ☐Bladder infection
- ☐Other _____

Past Surgeries and Procedures:

Please check all that apply (with dates if possible).

- ☐Colonoscopy
- ☐Upper endoscopy (EGD)
- ☐ERCP
- ☐Stomach or bowel surgery
- ☐Gallbladder removal
- ☐EUS
- ☐Appendectomy
- ☐Pacemaker
- ☐Cardiac defibrillator
- ☐Tonsillectomy
- ☐Organ Transplant
- ☐Hysterectomy
- ☐Recent X-Rays
- ☐Recent blood tests
- ☐Recent CT/Ultrasound
- ☐Other:_____
_____
_____

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Current Medication List:

Name / Dose / How Often

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies: _____

Family History:

			If yes, who				
Colon cancer	Y	N	_____	Diabetes	Y	N	_____
Colon polyps	Y	N	_____	Heart disease	Y	N	_____
Colitis / Crohns	Y	N	_____	High blood pressure	Y	N	_____
Stomach Cancer	Y	N	_____	Stroke	Y	N	_____
Esophageal cancer	Y	N	_____	Breast cancer	Y	N	_____
Pancreas cancer	Y	N	_____	Prostate cancer	Y	N	_____
Liver disease	Y	N	_____	Other			_____

Father living? Y N Current age (or age of death) _____ Cause of death _____
Mother living? Y N Current age (or age of death) _____ Cause of death _____

Do you have any children? Y N If yes, How many? _____ Are they healthy? Y N

Social History:

Marital status: (Circle one) M S D W Occupation: _____

Smoking History: Never Former Current Packs per day _____ For _____ years

Alcohol Use: Never Former Current # Drinks per week _____

Recent travel outside US? _____ Exercise? Y N How much per week? _____

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Review of systems:

Please check all symptoms you have had within the past year.

General/Constitutional:
___Chills
___Fever
___Night sweats
___Weight loss

Eyes:
___Blurred vision
___Trouble focusing
___Recent change in vision

Ears, Nose, Mouth and Throat
___Hearing loss
___Ringing in ears
___Dizziness
___Nosebleeds
___Difficulty swallowing
___Lip or mouth sores
___Sore throat

Endocrine:
___Diabetes
___Excessive thirst
___Excessive urination
___Thyroid disease
___Bleeding tendencies

Respiratory:
___Chronic cough
___Shortness of breath
___Oxygen use at home
___Blood in saliva
___Wheezing

Cardiovascular:
___Chest pain
___Irregular heart beat
___Swelling of ankles
___Heart murmur

Hematology:
___Abnormal clotting
___Easy bleeding
___Easy bruising
___Edema

Genitourinary:
___Blood in urine
___Burning on urination
___Difficult urination
___Frequent nighttime Urination

Musculoskeletal:
___Joint pain
___Joint swelling
___Muscle weakness
___Back pain

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand I am financially responsible for any balance. I also authorize *Digestive Health Services, SC* to release any information required to process my claims.

_____ _____
Patient/Guardian Signature Date

Patient name: _____ Date of birth: _____

Notice of Privacy Practices Acknowledgment

Digestive Health Services, SC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____