AVAMAR GATROENTEROLOGY AND CENTER FOR ENDOSCOPY- FARID NAFFAH MD & RONY AWAIDA MD #3

Your appointment is on _____at_____am / pm with Dr._____

You will need to bring the following items with you for this appointment:

□ This form- completed. □ Insurance card(s) □ Drivers license or Photo ID. □ All medication s you are currently taking.
□ Medication history form -completed □ Patient information and health history form- completed

Please note you must bring the actual prescription bottles of medication with you. Please include all over-the – counter and herbal supplements that you take on a regular basis. We require you to bring your medication(s) with you to all appointments. Thank you

Patient Information(print clearly)

Date:_____
First name_____
Last name_____
Address_____
_____
Home Phone # ( ) _____- _____
Cell Phone # ( ) _____- _____
Work Phone # ( ) _____- _____
Can our office leave a message on an answering machine, voicemail and/ or with a family member?
□ No □ Yes
Comment: _____
Date of Birth: _____/_____/_____ SEX M F

Social Security Number: _____-_____-_____
Are you Employed? □ No □ Yes
Employer:_____
Occupation:_____
Marital Status: M S D W
Who lives with you?_____
Spouse's name: _____
Parent or Guardian name:_____
Date of birth: _____/_____/_____

Social Security #: _____-_____-_____
Employer:_____
Cell Phone # : ( ) _____- _____
Work # : ( ) _____- _____

_____

HIPPA PRIVACY:

Who may we speak to if they should call on your behalf, regarding your health information at this practice?
Name_____ Phone# ( ) _____-_____
Relationship_____
Name_____ Phone# ( ) _____-_____
Relationship_____
Emergency Contact: A friend or family member that does not live with you that we may contact if we can't reach you? Name_____
Phone# ( )_____-_____ Relationship_____

Insurance information(print clearly)

Do you have health insurance? □ No □ Yes
If yes, please list the name(s) below and give the cards to the receptionist to copy.
1 .Primary Insurance: _____
2 .Secondary: _____
3. Other: _____

If No, please check (V) the box below if it applies to you.

□ I do not have health insurance and wish to be listed as **SELF PAY.** *(please contact patient accounts for payment arrangements.)*

_____

***PLEASE REMEMBER THAT WE MUST COLLECT ALL CO-PAYS ON THE DAY OF YOUR VISIT * YOU ARE RESPONSIBLE TO KNOW THE BENEFITS OF YOUR INSURANCE PLAN(S). CONTACT YOUR INSURANCE PLAN DIRECTLY WITH ANY QUESTIONS.**

Who is your primary care doctor? _____

What other doctors do you see on a regular basis?
Name_____/ Condition _____
Name_____ / Condition_____

What pharmacy do you use? Name_____
Location_____

What mail order Pharmacy do you use?
Name_____

How were you referred to our practice? Check(√) one
□ My doctor □ Patient □ Friend □ Other
Name_____

Do you have **ADVANCED DIRECTIVES** such as the following: Please check all that apply.
□ Living Will
□ Durable (medical) Power of Attorney
□ DNR (do not resuscitate orders)
□ None of the above.

AVAMAR GASTROENTEROLOGY, INC.-FARID NAFFAH, MD & RONY AWAIDA, MD **DATE _____**

PATIENT INFORMATION AND HEALTH HISTORY

FIRST NAME_____LAST NAME_____ DATE OF BIRTH_____

PERSONAL PAST OR CURRENT MEDICAL CONDITIONS

Please circle "No or Yes" to indicate if you currently have the following:

Gastrointestinal		
abdominal pain/ abdominal swelling	No	Yes
change in bowel habits	No	Yes
constipation	No	Yes
diarrhea	No	Yes
excessive gas	No	Yes
heartburn	No	Yes
Nausea/ Vomiting	No	Yes
difficulty swallowing (food)	No	Yes
Early satiety (getting full too quickly when eating)	No	Yes
rectal bleeding	No	Yes
Anemia	No	Yes
Unintentional weight loss	No	Yes
Black tarry stool	No	Yes
Other::		

*****PLEASE CIRCLE "No or "Yes" TO INDICATE IF YOU CURRENTLY HAVE OR HAD THE FOLLOWING CONDITIONS**

GASTROINTESTINAL			**CARDIAC/VASCULAR**			**ENDOCRINE/METABOLIC**			**OPTHALMIC**		
Polyps	No	Yes	High blood pressure	No	Yes	Diabetes	No	Yes	Cataracts	No	Yes
Peptic ulcer disease	No	Yes	Low blood pressure	No	Yes	Thyroid disorder	No	Yes	Glaucoma: if Yes □open □ closed Doctor _____	No	Yes
GERD (heartburn)	No	Yes	Angina	No	Yes	Adrenal insufficiency	No	Yes			
Irritable bowel	No	Yes	Irregular heart beat	No	Yes						
Crohn's disease	No	Yes	Atrial fibrillation	No	Yes	**GENITOURINARY**			Blindness	No	Yes
Colon cancer	No	Yes	Coronary artery disease	No	Yes	Kidney stones	No	Yes	**EAR/NOSE/THROAT**		
Ulcerative colitis	No	Yes	Pacemaker	No	Yes	Kidney disease	No	Yes	Deafness	No	Yes
Gallbladder disease	No	Yes	Defibrillator	No	Yes	Hemodialysis	No	Yes	Deviated septum	No	Yes
Colostomy (with bag)	No	Yes	Congestive heart	No	Yes	Peritoneal dialysis	No	Yes	Nosebleeds	No	Yes
Ileostomy (with bag)	No	Yes	Heart attack	No	Yes	Dark urine	No	Yes	Loose teeth	No	Yes
			Stents	No	Yes	**NEUROLOGICAL**					
			Blood clots	No	Yes	Seizures	No	Yes	**PSYCHOSOCIAL**		
			Endocarditis	No	Yes	Stroke	No	Yes	Alcoholism	No	Yes
			Congenital anomaly	No	Yes	Severe weakness	No	Yes	Substance abuse	No	Yes
			Aneurysm	No	Yes	Migraines (frequent)	No	Yes	Depression	No	Yes
			Chest pains	No	Yes				Anxiety disorder	No	Yes
									Mental breakdown	No	Yes
HEPATIC			**RESPIRATORY**			**MUSCULOSKELTAL**					
Liver disease	No	Yes	Asthma	No	Yes	Muscle disease	No	Yes			
Hepatitis	No	Yes	Emphysema (COPD)	No	Yes	Arthritis	No	Yes	**OTHER MISC.**		
Jaundice (yellow skin)	No	Yes	Bronchitis	No	Yes	Rheumatoid Arthritis	No	Yes			
Pancreatitis	No	Yes	Pneumonia	No	Yes	Neck pain (chronic)	No	Yes			
Cirrhosis	No	Yes	Sleep apnea	No	Yes	Back pain (chronic)	No	Yes			
HEMATOLOGY			Tuberculosis	No	Yes						
Blood disorder	No	Yes	Tracheostomy	No	Yes	**SKIN**					
Sickle cell anemia	No	Yes				Bruise easily	No	Yes			
HIV virus / AIDS	No	Yes				Skin disease	No	Yes			
Other:	No	Yes				Rash	No	Yes			

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FIRST NAME_____ **LAST NAME**_____
DATE OF BIRTH_____

TB Screening:
Do you have any of the following symptoms? □ Persistent cough lasting greater than 2 weeks □ Unexplained weight loss □ Night sweats (frequent)
□ Unexplained fever □ Loss of appetite □ Blood tinged sputum

PERSONAL HISTORY OF CANCER
Do you have a personal history of cancer? □ Yes □ No
If yes, please check what cancer **YOU** have or had below.

□ Colon Cancer □ Breast Cancer □ Prostate Cancer □ Uterine Cancer □ Ovarian Cancer □ Other_____
□ Other_____ □ Other_____ □ Other_____
□ **Other** □ **Other** □ **Other**

PREVIOUS SURGERY
□ None
Have you had any of the following surgeries?

□ Hysterectomy □Complete □ Partial	When_____	Where_____
□ Appendectomy	When_____	Where_____
□ Cholecystectomy (gallbladder)	When_____	Where_____
□ Gastric bypass	When_____	Where_____
□ Hernia Repair	When_____	Where_____
□ Heart/Coronary artery bypass graft (CABG)	When_____	Where_____
□ Heart valve repair/ replacement	When_____	Where_____
□ Aneurysm repair	When_____	Where_____
□ Other_____	When_____	Where_____
□ Other_____	When_____	Where_____
□ Other_____	When_____	Where_____
□ Other_____	When_____	Where_____
□ Other_____	When_____	Where_____
□ Other_____	When_____	Where_____
□ Other_____	When_____	Where_____
□ Other_____	When_____	Where_____

FAMILY HISTORY OF CANCER
Check (√) inside the box all cancers that apply to your family and list the family member on the line next to the cancer. (Example √ Father)

□ Colon _____	□ Uterine _____	□ Other _____
□ Breast _____	□ Prostate _____	□ Other _____
□ Ovarian _____	□ Other _____	□ Other _____

FAMILY HISTORY
Check (√) inside the boxes all conditions that apply to your family and list the family member on the line next to the condition.
Example √Asthma Mother

□ Alcoholism	_____	□ Hepatitis	_____
□ Anemia	_____	□ HIV/AIDS	_____
□ Arthritis/Rheumatism	_____	□ High blood pressure	_____
□ Asthma	_____	□ Crohn's disease	_____
□ Colonic polyps	_____	□ Ulcerative Colitis	_____
□ Depression	_____	□ Kidney disease	_____
□ Diabetes	_____	□ Lung disease	_____
□ Epilepsy/Seizures	_____	□ Mental disease	_____
□ Gallbladder disease	_____	□ Peptic ulcer disease	_____
□ Glaucoma	_____	□ Stroke	_____
□ Cataracts	_____	□ Sickle cell anemia	_____
□ Heart disease	_____	□ Thyroid disease	_____
□ Tuberculosis	_____	□ Skin disease	_____
□ other	_____	□ other	_____

AVAMAR GASTROENTEROLOGY, INC. - FARID NAFFAH MD & RONY AWAIDA MD

NAME _____ **DATE OF BIRTH:** _____

SOCIAL HISTORY

Tobacco Use Smoking Status: □ Never □ Yes □ Current every day smoker _____pks/day How many years? _____
□ Current some day smoker cigs/week_____ □ Former smoker pks/day_____ Number of years _____Quit date_____

Alcohol Use: □ None □ Yes, current. What do you usually drink? □ Beer □ Wine □ Liquor
How much? _____ drinks per □ day □ week □ month □ rarely, on a special occasion.
Former alcohol use drinks per day_____ week_____ month_____ number of years_____ Quit date_____

Caffeine Use: □ None □ Yes What do you usually drink? □ Coffee □ Tea □ Energy caffeinated drink s □ Soda
How much? _____ cups per □ day □ week □ month

Drug Use: □ None □ Use IV drugs currently. What IV drugs? _____
How often do you use IV drugs? □ daily □ weekly □ monthly □ Other_____
Used IV drugs in the past? □ No □ Yes What? _____ How often? _____
Recreation drug use (non-IV) currently? □ No □ Yes What? _____ _____ How often? _____
Recreational drug use in the past? □ No □ Yes What? _____ How often? _____

Have you traveled outside the country within the last 12 months? □ No □ Yes _____
Female Patients Only
Are you pregnant now? □ Yes □ No
When was your last menstrual period? (If applicable) _____

IMMUNIZATIONS

□ None □ Hepatitis A □ Hepatitis B □ Flu Vaccine □ Pneumonia □ Zoster (Shingles)

When_____ When_____ When_____ When_____ When_____

DIAGNOSTIC STUDIES & PROCEDURES

□ None

□ EGD (Upper Endoscopy)	□ Colonoscopy	□ Flexible Sigmoidoscopy	□ ERCP	□ MRCP
When_____	When_____	When_____	When_____	When_____
Where_____	Where_____	Where_____	Where_____	Where_____

CARDIAC PROCEDURE(S)

□ Cardiac Catheterization	□ Cardiac Stent Placement	□ Cardiac Ablation
When_____	When_____	When_____
Where_____	Where_____	Where_____

RADIOLOGY & OTHER

□ CT Abdomen/Pelvis	□ Abdominal Ultrasound	□ Liver Biopsy	□ Capsule (camera) Endoscopy
When_____	When_____	When_____	When_____
Where_____	Where_____	Where_____	Where_____

□ **Other Significant Test(s) or Procedure(s)**
When_____ Where_____

□ **Blood Work (labs**)
When_____ Where_____

Reviewed: □

_____ _____
Physician Signature: Date:

AVAMAR GATROENTEROLOGY, INC
FARID NAFFAH M.D. & RONY AWAIDA M.D.

DATE 4/10

MEDICATION HISTORY

PATIENT NAME:_____ DATE OF BIRTH_____

THE FOLLOWING INFORMATION IS VERY IMPORTANT TO YOUR HEALTH. PLEASE TAKE THE TIME TO FULLY AND ACCURATELY FILL OUT THIS FORM. *This information will remain confidential and will be part of your medical record. Thank you!*

ALLERGIES:

□ No Known Allergies □ No Known drug allergies

Please place a(√)checkmark inside the box if you have an allergy to any of the following. Write the reaction on the line. List any other allergies by placing a (√) mark in other and write the name of the medication and reaction on the line.

□ Penicillin_____	□ Morphine _____	□ Propofol _____ _	□ Aspirin_____
□ Sulfa_____	□ Fentanyl _____	□ Eggs _____	□ IVP Dye_____
□ Versed _____	□ Soy _____ __	□ other_____	□ other_____
□ Demerol_____	□ other_____	□ other_____	□ other_____
□ other_____	□ other_____ ___	□ other_____	□ other_____

Are you currently taking Coumadin/ warfarin? □ No □Yes If yes, for what reason? _____

Do you have any problems with anesthesia? □ No □ Yes If yes, please describe. _____

PLEASE LIST ALL PRESCRIPTION, OVER –THE –COUNTER, & HERBAL MEDICATIONS AND/OR SUPPLEMENTS.

	NAME OF MEDICATION/SUPPLEMEMNT	DOSAGE	HOW OFTEN DO YOU TAKE IT?	START DATE
1				
2.				
3.				
4.				
5.				
6.				
7.				
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9.				
10.				
11.				
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21.				
22.				
23.				
24.				
25.				

*Office use only: I have reviewed/verified this list with the patient and have entered it into the electronic health record.

_____ _____

Staff Signature Date