TDDC
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Khanh Le, MD

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Ilyas Memon, MD

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Atif Shahzad, MD

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Randy Chung, MD

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Office Phone: 281-764-9500

Office Fax: 281-764-9501

Website: www.tddctx.com

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To better assist you with your call needs, below is a list of our phone system options.

Option 1- Office Hours, Fax Number, and Office Locations

Option 2- Appointments and General Questions

Option 3- Billing Questions. Your call will be routed to our Central Business Office in Dallas.

**If your call is routed to our answering service during business hours, please leave a message. Our goal is to return your call within 1 to 2 hours. Multiple messages will delay response time. Thank you!

Thank you for choosing Texas Digestive Disease Consultants for your health care needs.

Attached is our new patient packet. As a reminder, there is an electronic version of these forms available for you to complete at the time of your appointment. However, if you're more comfortable with completing the forms by hand, please do so and bring the documents with you to your appointment. **Please DO NOT return your forms via email**.

In order to expedite your check in process, please register on our NEW patient portal prior to your appointment. You should have received an invitation to the portal at the time you scheduled your appointment. If you did not receive it, please call our office and we will be happy to resend the invite. Please complete the Health Summary section and click "SEND". This allows us to update your information instantly and save you time at check in!

If you did not complete this online Health Summary Section prior to your visit, you are required to check in 30 minutes prior to your scheduled appointment; otherwise, you only need to check in 15 - 20 minutes prior to your appointment.

What to bring:

1. Patient Packet Documents
   - Form 7.31, Limited Disclosure of PHI
   - Form 7.34, Disclosure of PHI via alternate means
   - Pages 8 - 13, **IF** you did not register on the patient portal
2. Insurance Card
3. Driver's License or State Issued ID
4. Medical Records, if applicable
5. Insurance Authorized Referral from your Primary Care, if applicable
6. Specialist Co-payment, which will be collected upon check-in. We accept Cash, Checks, Visa, MasterCard, and Discover.

Our office will verify your insurance eligibility and benefits 1 - 2 days prior to your appointment. We will make every effort to contact you prior to your appointment if we need additional information regarding your insurance coverage. However, it is important that you too verify our provider's participation to your insurance network and check if an authorized referral from your insurance carrier is required.

Please note, if you have an EPO or HMO plan, an authorized referral from your insurance carrier **WILL** be required. We would appreciate your assistance in obtaining one from your PCP for insurance carriers do not allow us to initiate these authorization requests. When contacting your PCP, please inform them to obtain the authorization for evaluation and treatment.

Please contact our office at 281-764-9500 should you need to cancel or reschedule your appointment.

We appreciate the opportunity to participate in your care.

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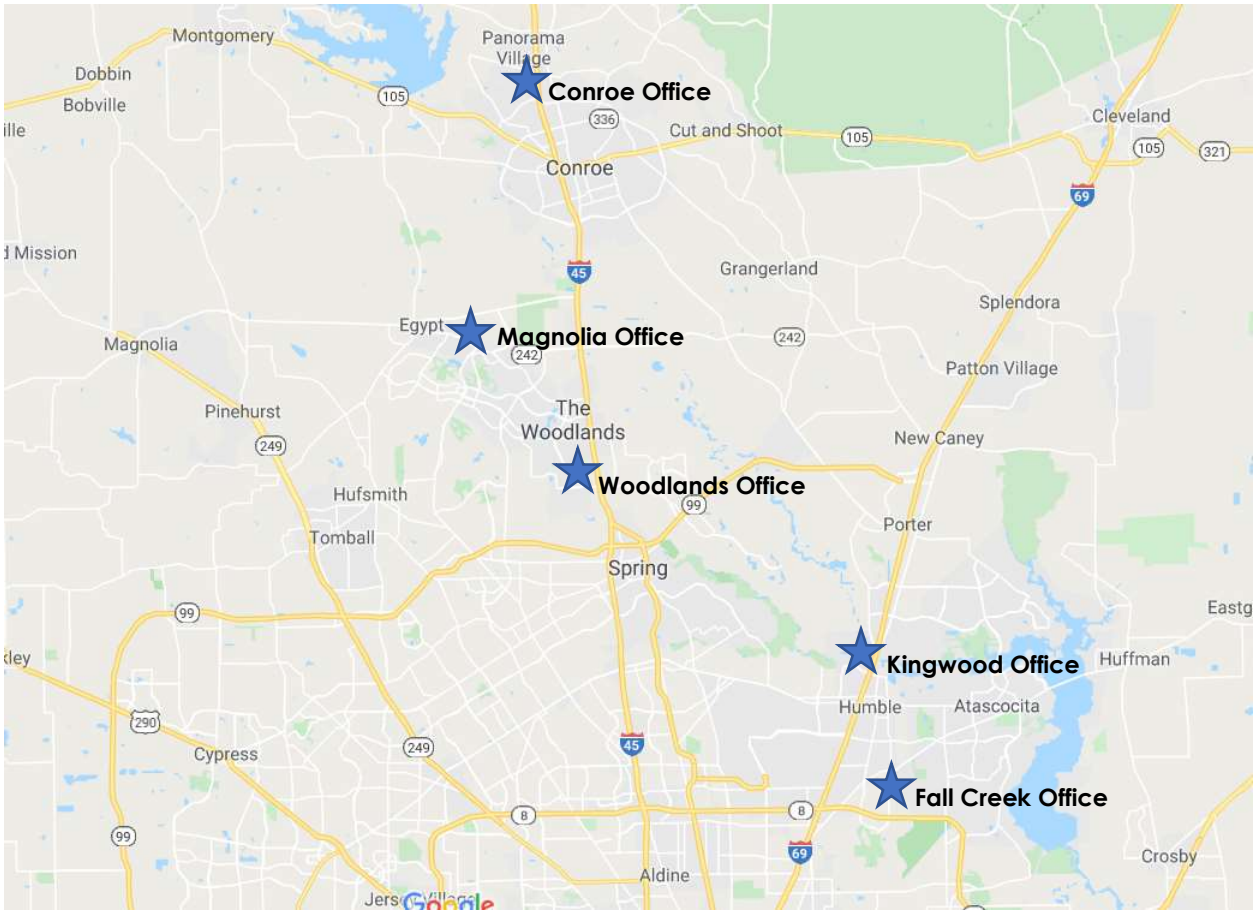
We have 5 locations to better serve you



Main Offices:

Woodlands: 26103 Interstate 45, Suite 100 Spring, TX 77380

Kingwood: 310 Kingwood Executive Drive, Suite B Kingwood, TX 77339

**Office Hours: Monday through Thursday 8:30am to 5:00pm. Friday 8:30am to 3:30pm (Phones open till 5:00pm)

Satellite Offices:

Humble: 9240 N Sam Houston Parkway E, Suite 202 Humble, TX 77396

Conroe: 4015 Interstate 45, Suite 210-02 Conroe, TX 77304

Magnolia: 10020 Research Forest Drive, Suite A Magnolia, TX 77354

**Our physicians have specific days and hours in which they are in our satellite offices.

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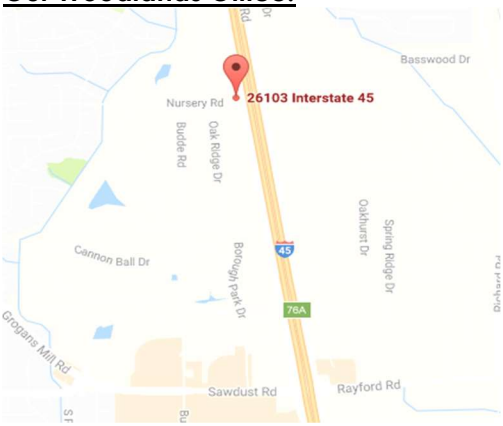
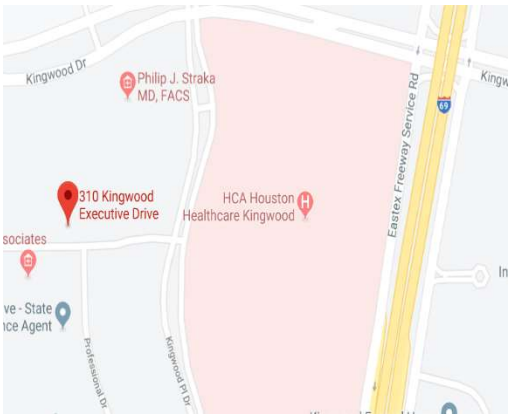
Our Woodlands Office:



Heading 45-North:
Exit Rayford/Sawdust
Turn LEFT onto Sawdust
Turn RIGHT onto Budde
Turn RIGHT onto Nursery
We are the last driveway on your left BEFORE the feeder road stop sign

Heading 45-South:
Exit Woodlands Parkway
Pass The Woodlands Mall and Olive Garden. In 2 - 3 minutes, you'll see our Gastroenterology sign.
We are on the corner of Nursery Rd and the Southbound feeder

Our Kingwood Office:

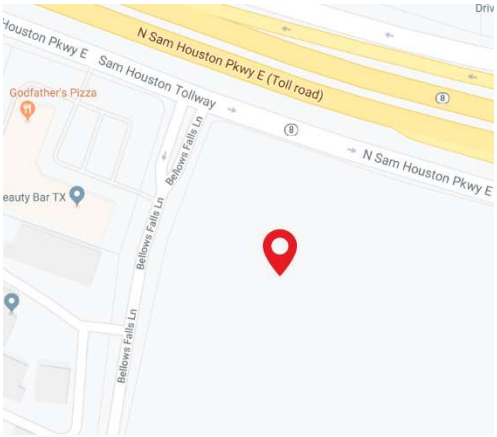


Heading 59-North:

Exit Kingwood Drive
Turn LEFT onto Kingwood Drive
Turn LEFT onto Kingwood Place Drive
Turn RIGHT onto Kingwood Executive Drive
We are the bright building on your RIGHT

Heading 59-South:
Exit Kingwood Drive
Turn RIGHT on Kingwood Drive
Turn LEFT onto Kingwood Place Drive
Turn RIGHT onto Kingwood Executive Drive
We are the bright building on your RIGHT

Our Fall Creek Office:



Heading Beltway 8 East:
Exit Mesa Rd
Pass Bellows Falls
Turn RIGHT into the driveway after Bellows Falls

Heading Beltway 8 West:
Exit Mesa Rd
Take U-Turn
Pass Bellows Falls
Turn RIGHT into the driveway after Bellows Falls

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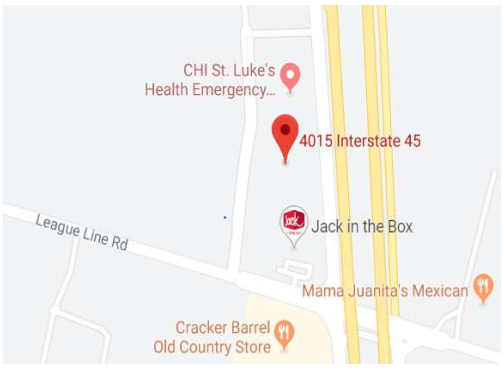
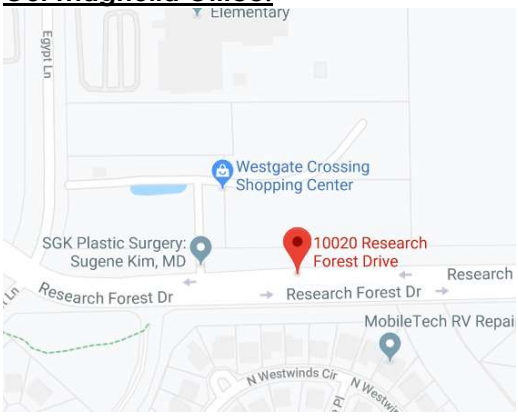
Our Conroe Office:



Heading 45-North:
Exit League Line Rd
Turn LEFT onto League Line Rd
Turn RIGHT onto the first street (unnamed road)
We are the in the Conroe-Willis Family Medicine Building

Heading 45-South:
Exit League Line Rd
Turn RIGHT onto League Line Rd
Turn RIGHT onto the first street (unnamed road)
We are the in the Conroe-Willis Family Medicine Building

Our Magnolia Office:



Heading 45-North:
Exit 1488
Turn LEFT onto 1488 and head towards Egypt Lane
Turn LEFT onto Egypt Lane
Continue on Egypt Lane towards Research Forest
Turn LEFT into the Magnolia Family Practice before you reach the light

Heading 45-South:
Exit 1488
Turn RIGHT onto 1488 and head towards Egypt Lane
Turn LEFT onto Egypt Lane
Continue on Egypt Lane towards Research Forest
Turn LEFT into the Magnolia Family Practice before you reach the light

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected Health Information (PHI) about you is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services. Our practice must maintain the privacy of PHI under a federal law known as the Health Insurance Portability and Accountability Act (hereafter "HIPAA") and requirements called the "Privacy Rule." Certain types of health information, such as regarding HIV, AIDS, mental health, substance abuse and genetic information, may also have additional protections under applicable state law. Under HIPAA and the Privacy Rule, our practice must provide you with this Notice of its legal duties and privacy practices with respect to PHI and must follow the terms of the Notice that is currently in effect. This Notice explains how our practice provides that protection. This Notice applies to The GI Alliance and its HIPAA-covered subsidiaries and affiliates which are under common control and/or common ownership, designated for HIPAA purposes as an affiliated covered entity.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required by law to follow the terms of this Notice. We will provide you with a paper copy of our current Notice if you call our office and request that a copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and on the GI Alliance website at : https://gialliance.com/patient-portal/noticeofprivacypractices. We reserve the right to change the terms of the Notice and to make the new Notice provisions effective for all PHI that we maintain. A revised Notice will be available at the practice and on the GI Alliance website.

You have the right to authorize other use and disclosure - This means your PHI will not be disclosed to anyone without your express written authorization, except as indicated in the section below titled How We May Use or Disclose PHI Without your Authorization or Consent. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or for a sale of PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider or our practice has already taken action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. Your request must be in writing, signed by you or your personal representative, and must inform us how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies. In certain cases, we may deny your request, and you may have the

right to appeal that decision. If we approve your request, we are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - You may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations, or with certain persons involved in your care (such as members of your family, other relatives or close personal friends). If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We must agree to this specific requested restriction for payment or healthcare operations purposes, unless disclosure is otherwise required by law. You have the right to request termination of an existing restriction.

You have the right to request an amendment to your PHI* - You may submit a written request to amend your PHI for as long as we maintain this information. Your written request must be signed by you or your personal representative and must state the reasons for the amendment/correction request. In certain cases, we may deny your request.

You have the right to request an accounting of disclosures* - You may submit a written request, signed by you or your personal representative, for a listing of certain disclosures made by us of your PHI. We will not charge a fee for the first accounting provided in a 12-month period; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a Breach of your Unsecured PHI, as defined by HIPAA, and determines through a risk assessment that notification is required by law.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please contact our Privacy Officer. Contact information is provided at the end of this Notice.

How We May Use or Disclose PHI Without your Authorization or Consent

As permitted by HIPAA, our practice can use or disclose your PHI, without your written consent or authorization, for the purposes listed below. We have provided a description and example below, but this list is not exhaustive; not every particular use or disclosure in every category will be listed.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other healthcare providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. For example, this may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose your PHI, as needed, in order to support the business activities of our practice. This includes, but is not limited to, business planning and development, quality assessment and improvement, training, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, provide information that describes or recommends treatment alternatives regarding your care, or provide information about health-related benefits, products and services that may be of

interest to you. We may contact you regarding fundraising, but you have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may use a health information organization, or other such organization, to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative** or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., unconscious or in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed. **A personal representative is a person permitted by law to make health care decisions on your behalf, such as someone who has a court order to do so or who has signed a valid power of attorney that includes the right to make health care decisions.

Other Permitted and Required Uses and Disclosures – We may disclose your PHI without your written consent or authorization when required by law or as otherwise permitted under HIPAA. Some examples of such disclosures include, but are not limited to: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas/discovery requests that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, veterans, inmates, correctional institutions, national security, etc.); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; to assist in disaster relief efforts; to Business Associates; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Incidental Disclosures - Subject to applicable law, we may make incidental uses and disclosures of PHI; these are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services, if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint. You may ask questions about your privacy rights, file a complaint or submit a written request (for access, restriction, amendment of your PHI, or to obtain an accounting of disclosures) by notifying our Privacy Officer in writing at Facsimile: 682-477-4367 OR 550 Reserve Street, Suite 550, Southlake, TX 76092:

Effective Date: 10/29/2019

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Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31

Please print all information. Form must be signed and dated each year.

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information:

Texas Digestive Disease Consultants

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays;
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

_____ _____
patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.

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Patient Authorization for Disclosure of Protected Health Information via Alternative Means

Form 7.34

Please print all information, then sign and date authorization form at bottom.

Patient Name: _____ **Date of Birth:** _____

Purpose of Authorization – It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, *"by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care."* The practice requires the following authorization for release of protected health information (PHI) via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

☐ cell phone: ☐ email address: ☐ US Mail: ☐ fax number: ☐ phone:

_____

Description of information to be disclosed - I authorize the practice to disclose the following PHI about me. *(Provide a written description of the information to be disclosed.)*:

_____

_____

Purpose of disclosure – I am authorizing the alternative means of communication for disclosure of my PHI to ensure the confidentiality of communications from the practice.

Expirations or termination of authorization – This authorization will renew automatically, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

(Please list desired expiration date): _____

Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in person or by mailing a written request to the practice, Attn: Privacy Manager.

Non-Conditioning Statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

Redisclosure Statement – I understand that the practice has no control regarding persons who may have access to the mailing or email address, telephone, cell or fax number I have designated to receive my PHI. Therefore, I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.

Secure Communication – Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email as your preferred method of communication if this is of concern to you.

_____ _____
patient signature date

Copies of signed authorizations are available upon request.

ATTENTION PATIENTS

The following pages (the Patient Interview forms) can be completed electronically via our patient portal.

If you provided your email address at the time you scheduled your appointment, you should have received an invitation to the portal.

If you did not receive the invitation, please call our office at 281-764-9500 and we will be happy to resend the invite so that you can register on the patient portal and complete your Health Summary Section.

Otherwise, please take a moment to complete the following pages and bring them with you to your appointment.

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Patient Interview Form- Formulario de entrevista con el paciente

Patient Information - Información del paciente

First Name:_____ Last Name:_____
(Nombre) (Apellido)
MRN:_____ Date of Birth:_____
(No. Historia Clinica) (Fecha de nacimiento)
Age:_____
(Edad)

Email- Correo electrónico
Please check one as your preferred email for communications – (Marque uno como su correo electrónico preferido para las comunicaciones)
☐ Personal:_____ ☐ Work:_____
(Laboral)

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino (No Hispano o Latino) ☐ Patient declines to specify (El paciente no desea especificar) ☐ Prohibited by state law (Prohibido por ley estatal)

Race
Select one or more
☐ White (Blanca) ☐ Black or African American (Negro o afroamericano) ☐ Asian (Asiático) ☐ American Indian or Alaska Native (Indio americano o nativo de Alaska) ☐ Native Hawaiian or other Pacific Islander (Nativo de Hawái u otro isleño del Pacífico)
☐ Unknown (Desconocido) ☐ Patient declines to specify (El paciente no desea especificar) ☐ Prohibited by state law (Prohibido por ley estatal)

Preferred Language
☐ English (Inglés) ☐ Korean (coreano) ☐ Spanish; Castilian (Español; Castellano) ☐ Patient declines to specify (El paciente no desea especificar)

Contact Preference
☐ Telephone call (Llamada telefónica) ☐ Portal ☐ Patient declines to specify (El paciente no desea especificar) Other:_____ (Otro)

Allergies – Alergias

☐ Patient has no known allergies
El paciente no tiene alergias
☐ Patient has no known drug allergies
El paciente no tiene alergias

☐ Aspirin (Aspirina) ☐ Cipro (Cipro) ☐ Codeine (Codeina) ☐ Demerol ☐ Fentanyl
☐ Flagyl ☐ Iodine (Iodo) ☐ IV dye (Tinte) ☐ Levaquin ☐ Morphine (Morfina)
☐ Penicillins (Penicilinas) ☐ Versed (Versado) ☐ Sulfa ☐ Eggs (Huevos) ☐ Latex
☐ Nuts (Nueces) ☐ Shellfish (Mariscos) ☐ Manifestations/Reactions: (Manifestaciones/reacciones) _____ Other:_____ (Otro)

Immunizations - Vacunas

☐ None (Ninguno)

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Hepatitis B	Hepatitis A	Influenza Vaccine (Antigripal)	Pneumovax Vaccine	Tetanus vaccine (Antitetánica)
When:_____ Fecha:_____	When:_____ Fecha: _____	When:_____ Fecha:_____	When:_____ Fecha:_____	When:_____ Fecha: _____

Current Medications - Medicamentos actuales

None (Ninguno)

Name (Nombre)	Dose (Dosis)	How taken? (Como se toman)

Pharmacy - Farmacia

Name (Nombre)	Address (Dosis)	Phone (Telefono)

Past Medical History - Antecedentes médicos

None (Ninguno)

Cancers:

Colon; Esophageal (Esófago); Liver (Higado); Small Intestine (Intestino Delgado)
Stomach (Estómago); Kidney (Riñón); Pancreas; Bladder (Vejiga)
Lymphoma(Linforma); Lung(Pulmó; Skin (Piel); Prostate (Prostata)
Breast (Mama); Cervical; Ovarian (Ovarios); Uterine (Uterino)
Other:_____ (Otro)

Liver: (Hígado)

Fatty liver (Higado graso); Hepatitis A active(activa); Hepatitis B, active(activa); Hepatitis C, active(activa)
Hepatitis, autoimmune; Other:_____ (Otro)

Digestive: (Digestivo)

Acid Reflux (Reflujo Acido); Barrett's Escphagus (Esogago fe Barrett); Celiac sprue (Celiaquia); Cirrhosis of Liver (Cirrosis Hepatica)
Colon Polyps (Polipos Colon); Crohn's disease (Enfermedad de Crohn); Diverticulitis (infected)(infectada); Divertivulosis
H. pylori; Irritable bowel Syndrome (Colon irritable); Pancreatitis; Ulcer (Ulcera)
Ulcerative colitis (Colitis ulcerosa); Other:_____ (Otro)

Miscellaneous: (Varios)

Anxiety/Panic attacks (Ataques de panico/ ansiedad); Arthritis(Artritis); Asthma (Asma); Atrial fibrillation (Fibrilacion auricular)
Congestive Heart failure (Insuficiencia cardiaca congestiva); Cornonary Artery Disease (Enfermedad de arteria coronaria); Depression (Depresion); Diabetes
Emphysema (Enfisema); Endometriosis; Fibromyalgia (Fibromialgia); Glaucoma
Heart attack (Ataque Cardiaco); High Blood Pressure (Hipertensio); High Cholesterol (Colesterol alto); HIV (VIH)
Kidney disease (Enfermedad renal); Lupus; Osteopenia; Osteoporosis
Seizure disorder (Trastorno Convulsivo Transitoria); Sleep apnea (Apnea de sueno); Stroke/TIA (ACV/ Isquemia); Thyroid (Hipertiroidismo), Overactive
Thyroid, Underactive (Hipotiroidismo); Other:_____ (Otro)

Supplements - If using the patient portal , please enter through the medication section instead. (Suplementos: si usa el portal del paciente, ingrese a través de la sección de medicamentos)

Please list vitamins (Indique las vitaminas):_____

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☐ Please list herbal supplements: (Indique suplementos herbales)

Previous Gastroenterology Procedures - Procedimientos de gastroenterología previos

☐ None (Ninguno)

☐ Colonoscopy (Colonoscopia)
☐ EGD - Upper Endoscopy (EGD/Endoscopia Superior)
☐ ERCP
☐ Endoscopic ultrasound/EUS (Ecografia endoscopica/EUS)
☐ Small bowel capsule (Capsula de intestino delgado)
☐ Liver biopsy (Biopsia de Higado)
Other: (Otro)

Surgical Procedures - Procedimientos quirúrgicos

☐ None (Ninguno)

☐ Appendectomy (Apendectomia Coronaria)
☐ C-Section (Cesarea)
☐ Cataract surgery (Cirugia de catarata)
☐ Colon resection (Reseccion de Colon)
☐ Coronary artery bypass (Bypass de arteria)
☐ Coronary/ Stent (Coronario/Stent)
☐ Defibrillator (Desfibrilador)
☐ Gallbladder (Removed) (Extirpación de vesícula)
☐ Gastric bypass (Bypass gastrico)
☐ Heart Valve replacement/repair (Reemplazo/reparación de válvula cardíaca)
☐ Hemorrhoidectomy (Hemorroidectomia)
☐ Hiatal Hernia Surgery (for reflux) (Cirugía de hernia hiatal (por reflujo))
☐ Hysterectomy partial (Ovaries intact) (Histerectomía, parcial (ovarios intactos))
☐ Hysterectomy (Ovaries removed) (Histerectomía, total (extirpación de ovarios))
☐ Inguinal Hernia Surgery (Groin) (Cirugía de hernia inguinal (ingle))
☐ Joint Surgery/ replacement (Cirugia/reemplazo de articulacion)
☐ Lap band (Banda gastrica)
☐ Liver transplant (Trasplante de hígado)
☐ Mastectomy (Mastectomia)
☐ Pacemaker (Marcapasos)
☐ Prostatectomy (Prostatectomia)
☐ Tonsillectomy (Amigdalectomia)
☐ Tubal ligation (Ligadura de trompas)
☐ Ulcer surgery (Cirugia de ulcera)
☐ Umbilical hernia surgery (belly-button) (Hernia umbilical (ombilgo))

Other: (Otro)

Social History- Antecedentes sociales

Occupation: (Ocupación)

Marital Status - Estado civil

☐ Single (Solter)
☐ Married (Casado)
☐ Divorced (Divorcia)
☐ Separated (Separado)
☐ Widowed (Viudo)
☐ Other (Otro)

Alcohol

☐ None (Ninguno)

☐ Less than 7 drinks per week (Menos de 7 tragos por semana)
☐ More than 7 drinks per week (Más de 7 tragos por semana)
☐ I quit using alcohol (Dejé de tomar alcohol)

Tobacco - Tabaco

Smoking Status

☐ Current Every day smoker (Fumador diario)
☐ Current Some Day Smoker (Fumador ocasional actual)
☐ Former smoker (Ex fumador)
☐ Never smoker (Nunca fumó)
☐ Smoker, current status unknown (Fumador, estado actual desconocido)
☐ Light tobacoo smoker (Fumador de tabaco liviano)
☐ Heavy Tobacco Smoker (Fumador de tabaco pesado)
☐ Unknown if ever smoked (Se desconoce si fumó alguna vez)

☐ Cigar (Cigarro)
☐ Chewing tobacco (Masca tabaco)

Drug Use - Consumo de drogas

☐ None (Ninguno)

☐ I have used recreational drug in the past. (Consumí drogas recreativas)
☐ I am currently using recreational drugs. (Consumo actualmente drogas recreativas)
☐ I have been treated for substance abuse. (Me sometí a tratamiento por abuso de sustancias)

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Family Medical History - Antecedentes familiares

No knowledge of family history (Se desconoce el antecedente familiar)

No family history of (No Hay) Colon cancer (Cancer de) Polyps (Polipo)

	Mother (Madre)	Father (Padre)	Sister (Hermana)	Brother (Hermano)	Son (Hija)	Daughter (Hijo)	Maternal Grandmother (Abuela materna)	Maternal Grandfather (Abuelo materno)	Paternal Grandmother (Abuela paterna)	Paternal Grandfather (Abuelo paterno)	Maternal Aunt (Tia Materna)	Maternal Uncle (Tio Materno)	Paternal Aunt (Tia Paterna)	Paternal Uncle (Tio Paterno)	Other (otro)
Diagnoses															
Colon Cancer (Cancer de Colon)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colon polyps (Polipos en el Colon)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Crohn's disease/Ulcerative colitis (Enfermedad de Crohn- colitis ulcerosa)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Liver disease (Enfermedad hepática)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Kidney cancer (Cáncer de riñón)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Uterine cancer (Cáncer de útero)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stomach cancer (Cáncer de estómago)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Bladder cancer (Cáncer de vejiga)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pancreatic cancer (Cáncer de páncreas)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ovarian cancer (Cáncer de ovarios)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Review Of Systems - Revisión de sistemas

Gastrointestinal

None (Ninguno)	Y	N
abdominal pain (Dolor abdominal)	○	○
anorectal pain/itching (Picazon/dolor anorrectal)	○	○
black tarry stools (Heces alquitranadas)	○	○
bloating/gas (Hinchazon/gases)	○	○
blood in stool (Sangre en heces)	○	○
change in bowel habits (Cambio de hábitos intestinales)	○	○
constipation (Estreñimiento)	○	○
diarrhea (Diarrea)	○	○
stool incontinence(leakage) (Incontinencia de heces)	○	○
hearburn/reflux (Acidez/reflujo)	○	○
difficulty swallowing (Dificultad para tragar)	○	○
nausea (Náuseas)	○	○
Vomiting (Vomitos)	○	○

Genitourinary

None(Ninguno)	Y	N
blood in urine (Sangre en orina)	○	○
dark urine (Orina oscura)	○	○
enlarged prostate (Próstata agrandada)	○	○
frequent urinary infections heavy (Infecciones urinarias frecuentes)	○	○
menstruation (Menstruación abundante)	○	○
pain/burning with urination (Dolor/ ardor al orinar)	○	○
pregnancy (Embarazo)	○	○
sexually transmitted disease (Enfermedad de transmisión sexual)	○	○
urinary incontinence frequent (Incontinencia urinaria)	○	○
urination (Micción frecuente)	○	○

Integumentary (Tegumentario)

None (Ninguno)	Y	N
itching (Picazón)	○	○
jaundice (Ictericia)	○	○
rashes (Erupciones)	○	○
suspicious lesions (Lesiones sospechosas)	○	○

Cardiovascular

None (Ninguno)	Y	N
heart murmur (Soplo cardíaco)	○	○
irregular heart beat (Latido irregular)	○	○
hand/ankle swelling (Hinchazón de manos/tobillos)	○	○
rapid heart rate/palpitations (Latido acelerado/palpitaciones)	○	○
shortness of breath (Falta de aliento)	○	○
chest pain (Dolor en el pecho)	○	○

Neurological (Neurológico)

None (Ninguno)	Y	N
frequent headaches (Cefaleas frecuentes)	○	○
memory loss/confusion (Pérdida de memoria-confusión)	○	○
numbness or tingling (Adormecimiento u hormigueo)	○	○

Endocrine (Endocrino)

None (Ninguno)	Y	N
cold intolerance (Intolerancia al frío)	○	○
excessive thirst (Sed excesiva)	○	○
heat intolerance (Intolerancia al calor)	○	○

Constitutional (Constitucional)

None (Ninguno)	Y	N
chills (Escalofríos)	○	○
fatigue (Fatiga)	○	○
fever (Fiebre)	○	○
loss of appetite (Pérdida de apetito)	○	○
night sweats (Sudoración nocturna)	○	○
weight gain (Aumento de peso)	○	○
weight loss (Pérdida de peso)	○	○

Psychiatric (Psiquiátrico)

None (Ninguno)	Y	N
anxiety (Ansiedad)	○	○
bipolar disorder (Trastorno bipolar)	○	○
depression (Depresión)	○	○

ENMT (OTORRINOLARINGOLOGÍA)

None (Ninguno)	Y	N
double vision (Visión doble)	○	○
eye irritation (Irritación ocular)	○	○
eye pain (Dolor ocular)	○	○
eye redness (Enrojecimiento ocular)	○	○
sore throat (Dolor de garganta)	○	○
hoarseness (Ronquera)	○	○
mouth sores (Llagas en la boca)	○	○
nose bleeds (Hemorragias nasales)	○	○
post-nasal drip recurrent sinus infections (Sinusitis recurrentes)	○	○

Hematologic/Lymphatic (Hematológico/linfático)

None (Ninguno)	Y	N
anemia	○	○
blood transfusions (Transfusiones de sangre)	○	○
easy bruising (Hematomas frecuentes)	○	○
prolonged bleeding (Sangrado prolongado)	○	○

Musculoskeletal (Musculoesquelético)

None (Ninguno)	Y	N
back pain (Dolor de espalda)	○	○
joint pain (Dolor de articulaciones)	○	○

Respiratory (Respiratorio)

None (Ninguno)	Y	N
frequent cough (Tos frecuente)	○	○
shortness of breath (Falta de aliento)	○	○
snoring (Ronquido)	○	○
sleep apnea (Apnea de sueño)	○	○
wheezing (Sibilancia)	○	○

Allergic/Immunologic (Alérgico/inmunológico)

None (Ninguno)	Y	N
allergies (Alergias)	○	○
HIV exposure (Exposición al VIH)	○	○
immune deficiency (Inmunodeficiencia)	○	○

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.
(Otorgo consentimiento para obtener el historial de mis medicamentos adquiridos en farmacias.)

○ Yes (Si) ○ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.
(Me gustaría recibir recordatorios de atención preventiva y de seguimiento.)

○ Yes (Si) ○ No

Reviewed with

○ Patient (Paciente) ○ Parent (Padre) ○ Guardian (Tutor) ○ Not Present (No presente)

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Signature - Firma

Signature
(Firma)

Date
(Fecha)