Florida Digestive & Liver Specialists, P.A.
25 Silver Palm Ave, Suite B
Melbourne, Florida 32901
Phone 321-725-4150

Patient Demographics

First Name: _____MI:____ Last Name: _____SS#_____

Date of Birth: _____Age:_____Place of Birth: _____Living Will: Y N

Sex: M F Marital Status: Single Married Widowed Separated Divorced

Previous Name: _____ Home#:_____Cell#_____

Address: _____City:_____State:_____Zip:_____

Mailing Address, If Different: _____

Race: _____ Ethnicity: _____Email:_____

Primary Doctor: _____Referring Doctor: _____

Preferred Pharmacy:_____ Pharmacy Address:_____

Emergency Contact: _____ Phone#: _____Relationship to PT: _____

Address: (If Different) _____City: _____State: _____Zip: _____

Patients Employer Name: (If unemployed, write none or retired) _____

Occupation: _____ Phone#: _____

Employer Address: _____City: _____State: _____Zip:_____

Primary Insurance: _____ID#_____

Secondary Insurance: _____ID#_____

Tertiary Insurance: _____ID#_____

Spouse's Last Name: _____First Name: _____ Date of Birth: _____

Spouse's SS#: _____ Cell#: _____ Work#: _____

PLEASE BE AWARE THAT IT IS YOUR RESPONSIBILITY TO VERIFY THAT DR. SHIREEN GADALLAH IS A PARTICIPATING/IN NETWORK PROVIDER WITH YOUR INSURANCE CARRIER. WE, FLORIDA DIGESTIVE & LIVER SPECIALISTS WILL NOT BE HELD RESPONSIBLE FOR ANY FEES NOT PAID BY YOUR INSURANCE COMPANY. YOU WILL RECEIVE A BILL FOR ANY SERVICES NOT COVERED BY YOUR INSURANCE.

Medicare Patients are responsible for informing Medicare of their secondary insurance, if applicable.

Patient Signature: _____Date: _____

Health History

Current Medications, Vitamins & Supplements: ☐ **None**

Drug Name	Strength	How Often

Drug Allergies:

_____

_____

_____

_____

Please list all surgical history below:

_____

_____

_____

_____

Are you Diabetic? Yes___ No___

Take blood-thinners? Yes___ No___

-If yes, do you take?

Coumadin ____

Plavix ____

Aspirin ____

Prodaxa ____

Other _____

Social History

Marital Status:_____

Blood Transfusion Yes____ No____

Vegetarian? Yes____ No____

Smoke Cigarettes? Yes____ No____

-If yes, _____ packs per day

-Former smoker? Yes ____ No____

Chew Tobacco? Yes____ No____

Drink Alcohol? Yes____ No____

-If yes, _____ oz

-How often? _____

Current or Past IV drug use?

-Yes____ No____

Drink beverages with Caffeine?

-Yes____ No____

-If yes, _____ Cups/Day

On Special Diet? Yes____ No____

-If yes, what type?

_____

Current or Past IV drug use?

-Yes____ No____

Study of Systems

Please check the boxes of those conditions which affect you...

General

- ☐ Unexpected Weight Loss
- ☐ Recent Weight Gain
- ☐ Fever or Shaking Chills
- ☐ Night Sweats
- ☐ Swollen Glands
- ☐ Take Coumadin, Blood-thinners

Skin

- ☐ Severe Itching
- ☐ Persistent Rash
- ☐ Changing Moles
- ☐ Psoriasis

Head

- ☐ Severe Headaches
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Wear Hearing Aid
- ☐ Wear Dentures
- ☐ Loose Teeth
- ☐ Removable Bridge
- ☐ Bleeding Gums
- ☐ Severe Nosebleeds
- ☐ Frequent Sore Throats
- ☐ Persistent Hoarseness

Blood

- ☐ Blood Transfusion in Past 6 Months
- ☐ Prolonged Bleeding from Surgery
- ☐ Anemic in Past
- ☐ Ever Treated for Cancer
- ☐ Think I'm at High Risk for AIDS

Muscles and Joints

- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Arthritis or Joint Pain
- ☐ Frequent Back Pain

Heart and Lungs

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack in Past
- ☐ Fainting Spells
- ☐ Irregular Heartbeat
- ☐ Wear Pacemaker
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Can't Breathe When Flat
- ☐ Awaken Short of Breath
- ☐ Ankles Swell
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Artificial Valve
- ☐ Frequent Cough
- ☐ Cough up Sputum
- ☐ Cough up Blood
- ☐ Wheezing or Asthma
- ☐ Rheumatic Fever as Child

Digestive Tract

- ☐ Poor Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Frequent Heartburn
- ☐ Heartburn Awakens
- ☐ Trouble Swallowing
- ☐ Hiatal Hernia in Past
- ☐ Rectal Bleeding
- ☐ Black Bowel Movements
- ☐ Vomited Blood
- ☐ Ulcers in Past
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Lost Bowel Control or Soiling
- ☐ Constipation
- ☐ Bowel Habit Unpredictable
- ☐ Milk or Lactose Intolerance
- ☐ Colon Polyps in Past
- ☐ Colon Cancer in Past
- ☐ Liver Disease or Jaundice
- ☐ Gallstones

Kidneys

- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Frequent Urination
- ☐ Up Nights to Urinate
- ☐ Blood in Urine
- ☐ Painful Urination
- ☐ Slow Urination
- ☐ Leakage of Urine

Brain

- ☐ Epilepsy or Seizures
- ☐ Past Strokes

Emotions

- ☐ Often Depressed
- ☐ Cry Easily
- ☐ Overly Anxious
- ☐ Can't Handle Stress

Men Only

- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Erection Difficulties

Women Only

- ☐ Pregnant Now
- ☐ Planning Pregnancy
- ☐ Nipple Discharge
- ☐ Lump in Breast
- ☐ Vaginal Discharge
- ☐ Hot Flashes
- ☐ Non-period Bleeding
- ☐ Past Menopause
- ☐ Painful Intercourse
- ☐ Change in Periods
- ☐ Past Endometriosis

Thank you for completing this questionnaire.

Family Health History

Do these problems run in your family?

☐ Non-Contributory (Check box if answers are unknown)

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children
Diabetes								
Hypertension								
Heart Disease								
Stroke								
Peptic Ulcer								
Mental Illness								
Cancer								
Gallbladder Disease								
Asthma								
Colon Polyps								
Colon Cancer								
Crohn's Disease								
Ulcerative Colitis								
Pancreatic Cancer								
Cirrhosis of Liver								

How many?

Siblings: ___Brothers ___Sisters

Children: ___Son's ___Daughter

Florida Digestive and Liver Specialist

HIPAA CONTACT INFORMATION FORM

In order to assist you in receiving your health information from *Florida Digestive and Liver Specialist*, please complete this form.

Initial one:

_____ (Initial) *Florida Digestive and Liver Specialist* is permitted to share **ANY and ALL** medical information with the individuals listed below, including post surgical and sensitive information as stipulated by the State of Florida and information disclosed during surgery center visits.

_____ (Initial) *Florida Digestive and Liver Specialist* is permitted to share **ANY** medical information with the individual listed below, including post surgical information, and sensitive information as stipulated by the State of Florida, and information disclosed during surgery center visits.

EXCEPT _____

Persons authorized to receive my medical Information (Full name, Relationship, and Phone number):

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____

You may notify me with, appointment reminders and other information regarding my health information as follows:

___Message on answering machine (Phone number) _____

___Message on cell phone (Phone number) _____

___Email address _____

I give permission to *Florida Digestive and Liver Specialists* to access my local hospital records for continuity of care.

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Name: _____Signature _____

Patient- Print

DOB: _____ Date :_____

This authorization is **NOT** valid for the request of printed copies of your medical records. You and only you (or your legal personal representative) must sign a Health Information Release Form to obtain copies of your medical records

OFFICE POLICIES
Effective 9/1/2013

- Our patients are very important to us, and we strive to provide the best possible care to all of our patients. We would appreciate your consideration when booking appointments. If appointments need to be rescheduled or cancelled, we require 24 hours' notice or a fee of $50.00 will be billed to you. All no shows will be billed $50.00.
- Three no shows will result in patient being discharged from practice.
- Procedure appointments require 7 (seven) days' notice for cancellation or rescheduling or patient will be billed $100.00.
- As a courtesy to our patients, your secondary insurance will be submitted for payment. However, please be aware that it is your responsibility to obtain information and/or authorization required by your secondary insurance.
- If Medicare is your primary insurance, please inform Medicare that you have a secondary, if applicable.
- It is your responsibility to verify that Dr. Gadallah is in network with your insurance plan, as we accept both in and out of network plans. Therefore, we will not be responsible for any charges not paid by your insurance company.

Patient Signature:_____

Date:_____

Bowel Symptom Questionnaire

Name:

Doctor:

Date:

Which symptoms best describe you? Select all that apply.

Accidental loss or leakage of stool—sometimes unable to make it to the bathroom in time
Bowel accidents while unaware—no warning and/or while asleep
Frequent, loose, watery stools
Sudden or strong urge to go to the bathroom
Bowel accidents when passing gas
No bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms?

Approximately how many bowel incidents do you have per week?

Have you tried medications to help your symptoms? Yes No

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select number.

0	1	2	3	4	5	6	7	8	9	10

No Relief ***Complete Symptom Relief***

Behavior modifications tried?

(e.g., lifestyle changes, fiber, diet changes, physical therapy)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Select a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated ***Very Frustrated***

Are you interested in learning more about additional treatment alternatives to bowel medications?

Yes No

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