

Digestive Health Associates of Northern Michigan, P.C.

Acknowledgement of Receipt
Notice of Privacy Practices

I understand Digestive Health Associates of Northern Michigan, P.C.'s notice of privacy practices are available upon request and are also posted on the bulletin board in the waiting room of their office.

Patient Signature

Date

Print Name

Date of Birth

HEALTH HISTORY QUESTIONNAIRE



Name: _____
 Age: _____ DOB: _____ Male Female
 Today's Date: _____ Reason for Visit: _____
 Allergies: _____

PAST HISTORY (✓ all that apply)

- Seizure _____
- Stroke/TIA _____
- Head Injury(when) _____
- Congestive Heart Failure _____
- Heart Attack (when) _____
- High Blood Pressure _____
- Bleeding Clotting Problem
- High Cholesterol
- Asthma Emphysema
- Hiatal Hernia Ulcer
- Liver Disease Hepatitis
- Ostomies
- Kidney Disease Kidney Stone
- Diabetes Hypoglycemia
- Thyroid Problems
- Arthritis Limited Motion
- HIV AIDS
- Cancer/Tumor (site) _____
- Chemotherapy/ Radiation _____
- Depression Alcoholism
- Suicide Attempt
- Chronic Pain

LIST GASTROINTESTINAL

SURGERIES (approximate dates):

(Please use back for additional info)

OTHER SURGERIES:

MEDICINE (Type and Dosage)

REVIEW OF SYSTEMS – (Recently)

Constitutional

- Chills Fever
- Uneasiness Weight loss

HEENT

- Double Vision Ear Infection
- Eye Pain Nasal Congestion
- Sinus Infection Sore Throat

Respiratory

- Shortness of Breath
- Frequent Cough Wheezing
- Severe Chest Pain

Cardiovascular

- Chest Pain Extreme Edema
- Palpitations

Gastrointestinal

- Abdominal Pain
- Change in bowel habits
- Constipation Diarrhea
- Heartburn Vomiting of Blood
- Blood in Stool Black Stool
- Loss of appetite
- Nausea Reflux Vomiting

Genitourinary

- Painful Urination
- Blood in Urine
- Urinary frequency
- Urinary Incontinence
- Urinary Retention

Reproductive

- Breast lumps Breast Pain
- Vaginal discharge
- Penile discharge
- Sexual dysfunction

Metabolic/Endocrine

- Cold intolerance
- Excessive thirst
- Heat intolerance
- Enlarged Breast in Men

Neurological

- Dizziness Headache
- Numbness Tremors
- Vertigo

Psychiatric

- Anxiety Depression

- Increased Stress

Integumentary

- Contact allergy Hives
- Scratching Rash

Musculoskeletal

- Back Pain Muscle Pain
- Joint Pain

Hematologic/Lymphatic

- Easy bleeding
- Easy bruising
- Swollen Lymph Nodes

Immunologic

- Asthma
- Chemicals in work place
- Food allergies
- Immunosuppression
- Seasonal allergies

Other Medical Problems

FAMILY HISTORY

(List Family Member and Type)

- Heart Disease _____
- Cancer _____
- Colon Polyps _____
- Colon Cancer _____
- Diabetes _____
- Other _____

SOCIAL HISTORY

Occupation _____
 Smoke Cigarettes
 Packs per day _____
 For How Long _____
 Year Quit _____
 Drinks caffeine
 Cups per day _____
 Recreational drugs
 Consumes alcohol
 Frequency _____
 For how long _____
 Year quit _____

REVIEWED BY _____ **DATE** _____



“No Show” Policy For Office Visits & Procedures

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide adequate notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancelations made less than 24-48 hours notice, we are unable to offer that appointment slot to other people.

- Patients who fail to show for their scheduled office appointment or do not notify the office within 24 hours of their scheduled appointment time, shall be subject to a “No Show” penalty of \$50.00. In the event of an actual emergency and prior notice could not be given, consideration will be given - and an exception may be granted.
- Patients who fail to show for their scheduled procedure appointment or do not notify the office within 48 hours of their scheduled appointment time shall be subject to a “No Show” penalty of \$150.

We understand that special unavoidable circumstances may cause you to cancel within this time frame. Fees in this instance may be waived but only with management approval.

Please sign that you have read, understand, and agree to this “No Show” Policy.

Patient Signature

Date

Print Name

Date of Birth