Khaldoun A Debian M.D.

GASTROENTEROLOGY
PANCREATIC-BILIARY AND ADVANCE ENDOSCOPY

Date: _____ Social Security # _____

Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Tel: (___) ____-_____ Cell Num: (___) ____-_____ Work: (___) ____-_____

Email Address: _____ Fax: (____) ____-_____

Authorization to email or fax test result (to you and your PCP): ☐ Yes ☐ No

Ethnicity: _____ Race: _____ Languages Spoken: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Occupation: _____ Employer: _____

Name of Spouse: _____ Phone Num: (___) ____-_____

Spouse Date of Birth (if primary subscriber on insurance) _____

Do you authorize this person to contact us on behalf of you? ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____

Phone: (___) ____-_____ Alternative Number: (___) ____-_____

Primary Care Doctor: _____ Referred By: _____

Authorization

I hereby authorize my Insurance CO / Health Plan to pay Khaldoun A. Debian M.D. the medical, surgical and benefits allowable under my current coverage. Otherwise non covered professional services rendered will be paid in full by me. If I cannot pay in full I will make arrangements for monthly installments.

Signature: _____ Date: _____

Khaldoun A. Debian M.D.

Gastroenterology Consult History

Date: _____

In order to facilitate your consultation, please complete the following questionnaire.

Name: _____
Last First MI

Date of Birth: ___/___/_____ Sex: ___M ___F

Names & address of physicians whom you wish to receive a report of consultation:

_____
_____
_____

What is the reason for your visit today?

_____
_____
_____
_____

Past Medical History:
Please mark which of the following apply to you and explain it in the paragraph below.

Heart trouble: ☐ Heart attack ☐ Congestive heart failure ☐ Irregular rhythm
☐ High blood pressure ☐ Diabetes ☐ High cholesterol

Lung problems: ☐ Asthma ☐ Emphysema (COPD) ☐ Tuberculosis ☐ Pneumonia

Kidney disease: _____ **Cancer:**_____

Neurological problem: ☐ Stroke/paralysis ☐ Migraine headaches ☐ Seizures

Liver disease: ☐ Hepatitis___ ☐ Gallbladder stones

Ulcers: ☐ Stomach ☐ Duodenum ☐ Colon

☐ IBD ☐ Colon Polyps ☐ GERD

☐ Blood clots ☐ Rheumatoid Arthritis ☐ Lupus ☐Thyroid disease ☐Blood transfusion
☐ other: _____
_____
_____

Past Surgical History: Please list all surgeries and any serious accidents and dates:

_____
_____
_____
_____

Social History:

Social status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner
Exercise: What kind_____ How often: _____ ☐ None
Smoking: ☐ None ☐ Past ☐ Heavy ☐ Light ☐ Current How long (yrs/mo) ___
How Many Packs (day/wk) ___
Alcohol: ☐ None ☐ Past ☐ Current Drinks per wk ____ what kind_____
Num of Yrs___
IV Drug: ☐ None ☐ Past ☐ Current What kind_____
Inhalation Drugs: _____

Medications: *(including over the counter **medications** and **vitamins**)*

Name	Dose, How Often?	Name	Dose, How often?

Aspirin ☐ Yes ☐ No Plavix or Coumadin ☐ Yes ☐ No

Allergies to Medications: *(Please list & describe type of reaction)* ☐ **None**

_____
_____
_____

Family History:

	Age	Diseases if Any	(If Deceased) Age	Cause
Mother				
Father				
Sister				
Brother				
Kids				

Diets:
Coffee: ☐ Yes ☐ No Cups per day/wk ____**Tea:** ☐ Yes ☐ No If yes what kind _____
Fast Food: ☐ Yes ☐ No **Greasy/oily/fried foods** ☐ Yes ☐ No **Spicy Foods** ☐ Yes ☐ No
Estimate: Grams of fiber per day_____ Calories per day _____

Review of Systems:

Current Weight: _____ Height:_____

☐ Fever ☐ Chills ☐ Night Sweats ☐ Fatigue ☐ Insomnia ☐ Loss of appetite
☐ Weight loss ☐ Weight gain How much _____ Over what time period _____
☐ Chest pain ☐ Shortness of breath ☐ Palpitations

Mouth:
☐ No problems
☐ Sore tongue ☐ Sores in mouth ☐ Loss of taste
☐ Sour taste ☐ Dryness

Throat/ Esophagus:
☐ No problems
☐ Hoarseness ☐ Pain upon swallowing
☐ Difficult swallowing o Solids o Liquids
☐ Heartburn ☐ Regurgitation

Stomach/Intestine/Liver:
☐ No problems
☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Early Satiety
☐ Bloating ☐ Excessive belching/flatulence
☐ Constipation ☐ Diarrhea How many bowel movements a day/week_____
☐ Blood in stools ☐ Black stools
☐ Jaundice ☐ Itching

Other:
☐ No problems
☐ Anemia ☐ Bleeding tendency
☐ Burning upon urination ☐ Blood in urine
☐ Discharge from penis or vagina
☐ Venereal disease
☐Skin Lesions
☐Depression ☐ Anxiety ☐ Forgetfulness
☐ History of sexual abuse
☐ Back problems ☐ Arthritis ☐ Swelling in the joints

Have you ever had a ☐ Colonoscopy (full colon) ☐ Flex Sigmoidoscopy (partial colon)
Date: _____ Findings:_____
☐ EGD (Esophagogastroduodenoscopy)
Date: _____ Findings: _____

Other Concerns:
_____
_____

_____ _____
Signature **Reviewed with patient**