COLORADO GASTROENTEROLOGY
PROFESSIONAL LLC
CONSULTANTS IN LIVER AND DIGESTIVE DISEASES

Patient Health Questionnaire

Today's Date ___/___/___

Patient Name: ____________________________________ **Primary Doctor:** ________________________________

Person completing the form, if not patient: ____

Date of Birth: ___/___/___ Personal Information: __Married __Divorced __Single __Separated __Widowed

Occupation: ____ How long? ______________________________

Medical Conditions:

____
____
____
____
____

Medications: (List all, including birth control, over the counter medications, herbs and vitamins)

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

Hospitalizations/Surgeries: Patient Only

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____

Allergies: (List all medications and type of reaction)

____________________ ____________________
____________________ ____________________

Social History:

Smoking ___ Packs/day _____ Number of years smoking ____ If you quit, when? ____________

Alcohol use ___ Drinks/day ________________________________ If you quit, when? ____________

Cocaine, marijuana, etc. use ________ Recent travel: When __________ Where________________________

HEALTH OF FAMILY: (If no longer living, please note age and cause of death)

Father __________ Mother __________ Sister/Brother __________ Children __________

FAMILY HISTORY: (Indicate any known illnesses of family members and relationship to the patient)

Gallstones ____________________ Relation ____

Colon Polyps __________________ Relation ____

Colon Cancer _________________ Relation ____

Pancreatitis ___________________ Relation____

Liver Disease _________________ Relation ____

Other cancer __________________ Relation ____

Other illness __________________ Relation ____

Patient Name: ____ **Date of Birth:** ______________________

REVIEW OF SYSTEMS: Check all that apply to the patient's health history

GENERAL:

__Chronic fatigue
__Weight loss (amount____, time____)
__Weight gain (amount____, time____)
__Fever
__Anemia
__Bruise easily/bleed too long
__Cancer (type:_________________________________)
__Diabetes (diagnosed when? ____________________)
__Thyroid disease
__Less interest in doing things

EYES, EARS, NOSE & THROAT:

__Ringing in ears
__Ear infections
__Dizzy Spells
__Poor vision
__Glaucoma
__Sinus trouble
__Hoarseness
__Eye infections
__Cataracts

LUNGS:

__Pneumonia
__Asthma
__Shortness of breath
__Bronchitis
__Cough

HEART:

__Chest pain
__High blood pressure
__Irregular heart beat
__Palpitations
__Ankle swelling
__Blood clots

SKIN:

__Rashes
__Hives
__Allergic reactions
__Growths

URINARY:

__Urine infections
__Kidney stones
__Blood in urine
__Painful urination
__Decrease in urine force or flow
__Urination at night

BONES AND JONES:

__Arthritis/rheumatism
__Back pain
__Weak bones
__Swollen joints

NEUROLOGIC/PSYCHIATRIC:

__Stroke
__Tremor/hands shaking
__Numbness or tingling
__Headaches (frequent)
__Migraines
__Seizures
__Depression
__Nervousness
__Problems with sleeping
__Memory loss
__Anxiety
__Panic attacks

GASTROINTESTINAL:

__Diarrhea
__Heartburn
__Black stools
__Nausea
__Blood in stool
__Liver disease
__Trouble swallowing
__Constipation
__Stomach pain
__Poor appetite
__Vomiting
__Bloating
__Gas

Any additional information you feel is important:

____

For office use only:

DATE REVIEWED AND UPDATED: (Physician to sign and date)

______________________ ______________________ ________________________

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your personal protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including your demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care. This includes the coordination or management of your health care with a third party such as a specialist, pharmacy or laboratory that is assisting in your health care. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for your hospital admission.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. The activities include, but are not limited to, quality assessment, employee review, training of medical students, and credentialing.

Other Disclosures

We may use or disclose your protected health information in the following situations without your authorization: as required by law, for public health issues required by law such as communicable diseases reporting, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement requests, requests from coroners, funeral directors and organ donation centers, research, requests from the military, in interests of national security, and workers' compensation requirements.

Other disclosures will be made only with your consent and authorization.

You may revoke this authorization at any time in writing, except to the extent that your physician's office has taken action in reliance on the use or disclosure indicated in the authorization.

Midtown Medical Center I ♦ 2005 Franklin Street ♦ Suite 280 ♦ Denver, Colorado 80205 ♦ ph: 303-861-0808 ♦ fax: 303-861-2193

HIPAA Notice of Privacy Practices Page 2

Your Rights

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us to not use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted and you have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of the notice from us, upon request, even if you have agreed to this notice alternatively (i.e. electronically).

You have the right to request amendments to your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement.

You have the right to receive an accounting of certain disclosures we have made of your protected health information.

We reserve the right to change the terms of this notice and will inform you be mail of any changes. You then have the right to object or withdraw as provided in this notice.

If you believe your privacy rights have been violated, you may file a written complaint with the Privacy Officer. If you are not satisfied with the way Colorado Gastroenterology handles your complaint, you may also file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services.

This notice was published and becomes effective April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 303-861-0808.

Your signature below is only acknowledgement that you have received this Notice of Privacy Practices.

Name: ____________________________ Signature:_______________________ Date: ____________