

# **TDDC**

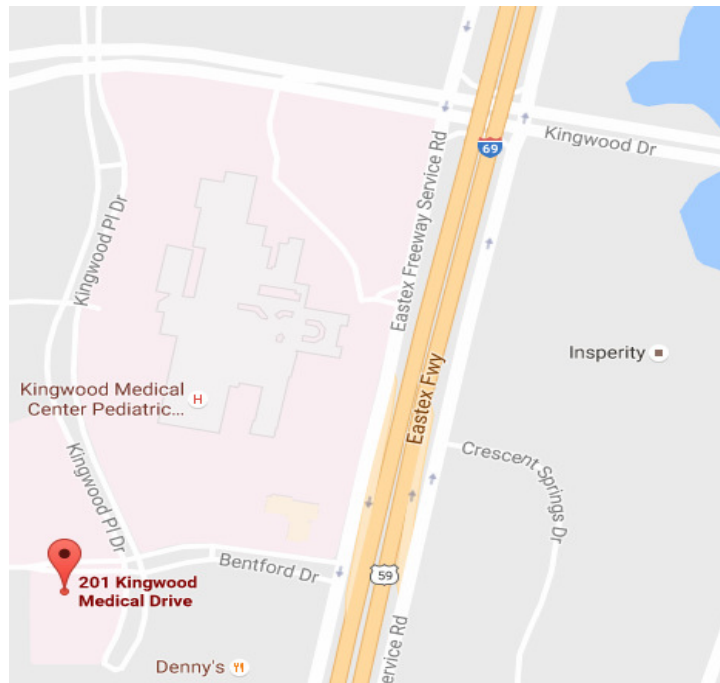
Texas Digestive Disease Consultants

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Office: 281•764•9500

Fax: 281•764•9501

**Our Kingwood Office:**  
201 Kingwood Medical Drive, Suite B-100  
Kingwood, TX 77339



**Heading 59-North:**

Exit Kingwood Drive  
U-TURN at Kingwood Drive  
Turn RIGHT onto Bentford  
Continue STRAIGHT on Bentford which turns into Kingwood Medical Drive  
Turn LEFT into Kingwood Executive Center parking lot

**Heading 59-South:**

Exit Kingwood Drive  
Continue Straight on the feeder road  
Pass Kingwood Medical Center and Silverado Memory Care  
Turn RIGHT onto Bentford  
Continue STRAIGHT on Bentford which turns into Kingwood Medical Drive  
Turn LEFT into Kingwood Executive Center parking lot

**Notice of Privacy Practices**  
**Texas Digestive Disease Consultants**

Form 7.20

This notice describes how medical information about you may be used and disclosed, and how you can gain 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 is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

### **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 to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised 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 within the practice, and if such is maintained by the practice, on its web site.

**You have the right to authorize other use and disclosure** - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. 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 if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an 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, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, 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 copy your PHI** - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

**You have the right to request a restriction of your PHI** - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. 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 will 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 are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to your protected health information** - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request a disclosure accountability** - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**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, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

page 1 of 2

### How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**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.

**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 and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

**Payment** - Your PHI will be used, as needed, to obtain payment for your healthcare services. 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, as needed, your PHI 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, medical review, legal services, auditing functions and patient safety activities.

**Health Information Organization** - The practice may elect to 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 the PHI, 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.

**Other Permitted and Required Uses and Disclosures** - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; 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.

### 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. You may file a complaint with us by notifying the Privacy Manager at:

(214) 424-2200

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We will not retaliate against you for filing a complaint.

Effective Date 9/23/2013

Publication Date 9/23/2013

**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.



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, x-rays, financial history report, nursing home, home health, hospice, record of HIV, record of mental health, 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 have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager.
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.

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.

**Patient Instructions for Form 7.31****Limited Patient Authorization for Disclosure of Protected Health Information**

The Limited Patient Authorization will give our office the authority to provide the person or entity you designate on the form with access to your protected health information (PHI). The Limited Patient Authorization is limited to accessing only the information that you designate and does not give any other rights to the person you have named on the form. Use of this form will enable us to provide your health information to a person or entity that may be involved in your healthcare.

The following outline will describe the information we will need on the form and its purpose. Please address any questions you have with our staff.

**Patient Name** - Print your name.

**Social Security Number and Date of Birth** - This information is needed for identity verification and will be maintained in a confidential manner at all times.

**Entity Requested to Release information** - This simply identifies who is to provide the information.

**Purpose of Request**- To disclose your protected health information to an individual.

**Who will be authorized to receive information** - Enter the name, address and phone number of the individual or entity that you are designating to receive the disclosure.

**Description of Information to be disclosed** - The type and amount of health information that we disclose is determined by you. We can disclose or provide access to all of your health information, or it can be limited to a specific item.

**Purpose of Disclosure** - Regulations require that we identify the purpose for disclosing limited information. You also have the right to keep the purpose to yourself by selecting "Patient Request."

**Expiration or Termination** - This authorization will expire at the end of the calendar year in which it was signed unless you specify an earlier termination. The authorization must be renewed each year as a means of protecting your information by verifying your wish to continue the authorization for disclosure.

**Right to Revoke or Terminate** - You may revoke or terminate the authorization at any time by submitting written notice to our Privacy Manager.

**Non-Conditioning Statement** - This simply states that our practice does not place conditions for treatment on the use of the authorization.

**Redisclosure Statement** - We cannot be responsible for what the receiving entity does with your health information that we provide under this authorization. The redisclosure statement simply informs you of this situation.

**Signature and Date** - We will need your signature and date of the signature to make the authorization effective.

**Copies** - We will provide you with a copy of this signed authorization upon request.





**PLEASE READ THIS VERY IMPORTANT INFORMATION REGARDING YOUR PROCEDURE.**

You have been scheduled for a gastroenterology procedure(s) under the care of a TDDC physician. TDDC wants to help by providing you the following information related to health plans and insurance that may affect processing of your claims.

- TDDC will work with your health plan representatives to obtain prior authorization for your gastroenterology procedure(s). Therefore, **it is imperative that TDDC is furnished with your applicable and current insurance information.**
- If your insurance plan requires a **referral authorization from a primary care physician, please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance company may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges.**
- TDDC will seek to verify medical benefits for planned procedures under your health plan. **If insurance verification indicates your services will not be covered, or that a significant portion of the cost will be your responsibility, our staff will attempt to contact you** to discuss your payment options prior to your procedure. **Whether you have been contacted or not, you are responsible for any balance after insurance processes your claim.**
- Employers now choose to purchase from a wide array of health care plans. Your health plan may have a benefit structure that will determine your out of pocket cost. We make every possible effort to obtain accurate benefits; however, our information is only as good as that provided by the health plan representatives. **For this reason, we urge you to review the health plan coverage information given to you by your employer or insurer to gain your own understanding of your insurance benefits.**
- **TDDC wants you to understand health plans may have different benefit structures for screening / diagnostic / therapeutic / surgical services.** Some services performed by gastroenterologists are done for "preventive" purposes (diagnostic) as a screening colonoscopy or screening due to family history of colon cancer or polyps. These same services can be performed because patients are experiencing signs or symptoms of illness and intervention / surgery may become part of the service provided. **Please refer to the colonoscopy informational insert if scheduled for this procedure as often a colonoscopy performed due to a personal history of polyps will be processed with the same benefits as a medical colonoscopy.**
- **TDDC wants you to be aware there will be charges related to your services from other health care providers in addition to our physician performing your procedure including :**  
 The **facility** in which you receive you care  
 The services of an **anesthesia provider.**  
 The services of **pathologists** if biopsies taken or polyps removed
- **Hospital based physicians such as pathologists and anesthesia provider may be out of network for your health plan, even if the hospital and the TDDC physician is in-network.** TDDC physicians do not have control over other hospital based providers' health plan participation.

If you have any questions concerning your insurance benefits, it is your responsibility to contact customer service at your insurance company. They will be happy to help you with any questions that you may have.

## **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.**





## 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 Clínica) (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  Patient declines to specify  Prohibited by state law  
 (No Hispano o Latino) (El paciente no desea especificar) (Prohibido por ley estatal)

#### Race

Select one or more

White  Black or African American  Asian  American Indian or Alaska Native  Native Hawaiian or other Pacific Islander  
 (Blanca) (Negro o afroamericano) (Asiático) (Indio americano o nativo de Alaska) (Nativo de Hawái u otro isleño del Pacífico)

Unknown  Patient declines to specify  Prohibited by state law  
 (Desconocido) (El paciente no desea especificar) (Prohibido por ley estatal)

#### Preferred Language

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

#### Contact Preference

Telephone call (Llamada telefónica)  Portal  Patient declines to specify  Other: \_\_\_\_\_  
 (Otro)  
 (El paciente no desea especificar)

### 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 (Codeína)  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)

<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Influenza Vaccine (Antigripal)	<input type="checkbox"/> Pneumovax Vaccine	<input type="checkbox"/> Tetanus vaccine (Antitetánica)
When: _____	When: _____	When: _____	When: _____	When: _____
Fecha: _____	Fecha: _____	Fecha: _____	Fecha: _____	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:**

<input type="checkbox"/> Colon	<input type="checkbox"/> Esophageal (Esófago)	<input type="checkbox"/> Liver (Higado)	<input type="checkbox"/> Small Intestine (Intestino Delgado)
<input type="checkbox"/> Stomach (Estómago)	<input type="checkbox"/> Kidney (Riñón)	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Bladder (Vejiga)
<input type="checkbox"/> Lymphoma(Linforma)	<input type="checkbox"/> Lung(Pulmó)	<input type="checkbox"/> Skin (Piel)	<input type="checkbox"/> Prostate (Prostata)
<input type="checkbox"/> Breast (Mama)	<input type="checkbox"/> Cervical	<input type="checkbox"/> Ovarian (Ovarios)	<input type="checkbox"/> Uterine (Uterino)

Other: \_\_\_\_\_ (Otro)

**Liver: (Hígado)**

<input type="checkbox"/> Fatty liver (Higado graso)	<input type="checkbox"/> Hepatitis A active(activa)	<input type="checkbox"/> Hepatitis B, active(activa)	<input type="checkbox"/> Hepatitis C, active(activa)
<input type="checkbox"/> Hepatitis, autoimmune	Other: _____ (Otro)		

**Digestive: (Digestivo)**

<input type="checkbox"/> Acid Reflux (Reflujo Acido)	<input type="checkbox"/> Barrett's Escphagus (Esogago fe Barrett)	<input type="checkbox"/> Celiac sprue (Celiaquia)	<input type="checkbox"/> Cirrhosis of Liver (Cirrosis Hepatica)
<input type="checkbox"/> Colon Polyps (Polipos Colon)	<input type="checkbox"/> Crohn's disease (Enfermedad de Crohn)	<input type="checkbox"/> Diverticulitis (infected)(infectada)	<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> H. pylori	<input type="checkbox"/> Irritable bowel Syndrome (Colon irritable)	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Ulcer (Ulcera)

Other: \_\_\_\_\_ (Otro)

**Miscellaneous: (Varios)**

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

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)

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### Previous Gastroenterology Procedures - Procedimientos de gastroenterología previos

- None (Ninguno)
- Colonoscopy (Colonoscopia)
- Liver biopsy (Biopsia de Hígado)
- EGD - Upper Endoscopy (EGD/Endoscopia Superior)
- ERCP
- Endoscopic ultrasound/EUS (Ecografía endoscópica/EUS)
- Small bowel capsule (Capsula de intestino delgado)
- Other: \_\_\_\_\_  
(Otro)

### Surgical Procedures - Procedimientos quirúrgicos

- None (Ninguno)
  - Appendectomy (Apendectomía Coronaria)
  - Coronary/ Stent (Coronario/Stent)
  - Hemorrhoidectomy (Hemorroidectomía)
  - Joint Surgery/ replacement (Cirugía/reemplazo de articulación)
  - Prostatectomy (Prostatectomía)
  - C-Section (Cesarea)
  - Defibrillator (Desfibrilador)
  - Hiatal Hernia Surgery (for reflux) (Cirugía de hernia hiatal (por reflujo))
  - Lap band (Banda gástrica)
  - Tonsillectomy (Amigdalectomía)
  - Cataract surgery (Cirugía de catarata)
  - Gallbladder (Removed) (Extirpación de vesícula)
  - Hysterectomy partial (Ovaries intact) (Histerectomía, parcial (ovarios intactos))
  - Liver transplant (Trasplante de hígado)
  - Tubal ligation (Ligadura de trompas)
  - Colon resection (Resección de Colon)
  - Gastric bypass (Bypass gástrico)
  - Hysterectomy (Ovaries removed) (Histerectomía, total (extirpación de ovarios))
  - Mastectomy (Mastectomía)
  - Ulcer surgery (Cirugía de úlcera)
  - Coronary artery bypass (Bypass de arteria)
  - Heart Valve replacement/repair (Reemplazo/reparación de válvula cardíaca)
  - Inguinal Hernia Surgery (Groin) (Cirugía de hernia inguinal (ingle))
  - Pacemaker (Marcapasos)
  - 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 (Divorcio)
- 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

- Cigar (Cigarro)
- Chewing tobacco (Masca 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 tobacco smoker (Fumador de tabaco liviano)
- Heavy Tobacco Smoker (Fumador de tabaco pesado)
- Unknown if ever smoked (Se desconoce si fumó alguna vez)

#### 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)

### 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyps (Polipos en el Colon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease/Ulcerative colitis (Enfermedad de Crohn- colitis ulcerosa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease (Enfermedad hepática)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney cancer (Cáncer de riñón)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine cancer (Cáncer de útero)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach cancer (Cáncer de estómago)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder cancer (Cáncer de vejiga)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic cancer (Cáncer de páncreas)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cancer (Cáncer de ovarios)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Review Of Systems - Revisión de sistemas**

<b>Gastrointestinal</b>	<b>Integumentary (Tegumentario)</b>	<b>ENMT (OTORRINOLARINGOLOGÍA)</b>
<input type="radio"/> None (Ninguno)      Y N	<input type="radio"/> None (Ninguno)      Y N	<input type="radio"/> None (Ninguno)      Y N
abdominal pain (Dolor abdominal)	itching (Picazón)	double vision (Visión doble)
anorectal pain/itching (Picazon/dolor anorectal)	jaundice (Ictericia)	eye irritation (Irritación ocular)
black tarry stools (Heces alquitranadas)	rashes (Erupciones)	eye pain (Dolor ocular)
bloating/gas (Hinchazon/gases)	suspicious lesions (Lesiones sospechosas)	eye redness (Enrojecimiento ocular)
blood in stool (Sangre en heces)	<b>Cardiovascular</b>	sore throat (Dolor de garganta)
change in bowel habits (Cambio de hábitos intestinales)	<input type="radio"/> None (Ninguno)      Y N	hoarseness (Ronquera)
constipation (Estreñimiento)	heart murmur (Soplo cardíaco)	mouth sores (Llagas en la boca)
diarrhea (Diarrea)	irregular heart beat (Latido irregular)	nose bleeds (Hemorragias nasales)
stool incontinence(leakage) (Incontinencia de heces)	hand/ankle swelling (Hinchazón de manos/tobillos)	post-nasal drip recurrent sinus infections (Sinusitis recurrentes)
heartburn/reflux (Acidez/reflujo)	rapid heart rate/palpitations (Latido acelerado/palpitaciones)	<b>Hematologic/Lymphatic (Hematológico/linfático)</b>
difficulty swallowing (Dificultad para tragar)	shortness of breath (Falta de aliento)	<input type="radio"/> None (Ninguno)      Y N
nausea (Náuseas)	chest pain (Dolor en el pecho)	anemia
Vomiting (Vomitos)	<b>Neurological (Neurológico)</b>	blood transfusions (Transfusiones de sangre)
<b>Genitourinary</b>	<input type="radio"/> None (Ninguno)      Y N	easy bruising (Hematomas frecuentes)
<input type="radio"/> None (Ninguno)      Y N	frequent headaches (Cefaleas frecuentes)	prolonged bleeding (Sangrado prolongado)
blood in urine (Sangre en orina)	memory loss/confusion (Pérdida de memoria-confusión)	<b>Musculoskeletal (Musculoesquelético)</b>
dark urine (Orina oscura)	numbness or tingling (Adormecimiento u hormigueo)	<input type="radio"/> None (Ninguno)      Y N
enlarged prostate (Próstata agrandada)	<b>Endocrine (Endocrino)</b>	back pain (Dolor de espalda)
frequent urinary infections heavy (Infecciones urinarias frecuentes)	<input type="radio"/> None (Ninguno)      Y N	joint pain (Dolor de articulaciones)
menstruation (Menstruación abundante)	cold intolerance (Intolerancia al frío)	<b>Respiratory (Respiratorio)</b>
pain/burning with urination (Dolor/ardor al orinar)	excessive thirst (Sed excesiva)	<input type="radio"/> None (Ninguno)      Y N
pregnancy (Embarazo)	heat intolerance (Intolerancia al calor)	frequent cough (Tos frecuente)
sexually transmitted disease (Enfermedad de transmisión sexual)	<b>Constitutional (Constitucional)</b>	shortness of breath (Falta de aliento)
urinary incontinence frequent (Incontinencia urinaria)	<input type="radio"/> None (Ninguno)      Y N	snoring (Ronquido)
urination (Micción frecuente)	chills (Escalofríos)	sleep apnea (Apnea de sueño)
	fatigue (Fatiga)	wheezing (Sibilancia)
	fever (Fiebre)	<b>Allergic/Immunologic (Alérgico/inmunológico)</b>
	loss of appetite (Pérdida de apetito)	<input type="radio"/> None (Ninguno)      Y N
	night sweats (Sudoración nocturna)	allergies (Alergias)
	weight gain (Aumento de peso)	HIV exposure (Exposición al VIH)
	weight loss (Pérdida de peso)	immune deficiency (Inmunodeficiencia)
	<b>Psychiatric (Psiquiátrico)</b>	
	<input type="radio"/> None (Ninguno)      Y N	
	anxiety (Ansiedad)	
	bipolar disorder (Trastorno bipolar)	
	depression (Depresión)	

**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)

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