Patient Name (print)	Date of Birth	Today's Date
EMAIL:	CELL PHONE:	

NAME OF REFERRING PHYSICAN:_____

NAME OF PRIMARY CARE PHYCIAN:_____

Please check any conditions that may apply:

GASTROINTESTINAL (DIGESTIVE)

- ☐ Rectal Bleeding
- ☐ Polyps
- ☐ Leakage of Stool
- ☐ Heartburn/Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty/pain swallowing
- ☐ Abdominal Pain
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating/belching/gas
- ☐ Hemorrhoids
- ☐ Black stool
- ☐ Weight loss
- ☐ Irritable bowel
- ☐ Ulcers
- ☐ Poor Appetite
- ☐ Hiatal Hernia
- ☐ Chest pain
- ☐ Hoarseness/cough
- ☐ Intestinal blockage
- ☐ Stomach cancer
- ☐ Colon cancer
- ☐ Liver problems
- ☐ Hepatitis A, B or C
- ☐ Crohn's/ Ulcerative colitis
- ☐ Gallbladder disease
- ☐ Pancreas Disease
- ☐ Colon cancer/polyp in family
- ☐ Abnormal lab/Radiology
- ☐ Anemia/Low Blood Count
- ☐ Other:_____

REASON FOR VISIT: [**If any item checked above, Please explain**]

LIST ALL PRESENT & PAST MEDICAL CONDITIONS:

_____ Heart Problems _____Lung Problems _____ Diabetes

_____ Bleeding Problems _____High Blood Pressure _____Stroke _____ Cancer

OTHER ILLNESSES:

LIST ALL PREVIOUS SURGERIES AND INCLUDE YEAR:

FAMILY HISTORY: List any medical conditions and age:

Mother:_____Children:_____

Father:_____Siblings:_____

Any family history of colon cancer, polyps or liver disease? _____

SOCIAL HISTORY:

Occupation:_____

Do you smoke? ___YES ___NO If yes, how much?_____

Do you drink? ___YES ___NO If yes, how much?_____

Marital Status: **M S D W**

LIST ALL MEDICATION

ALLERGIES:_____

LIST ALL MEDICATIONS (INCLUDING OVER THE COUNTER) NAME, STRENGTH, FREQUENCY:

_____

_____

Reviewed:_____Date_____

T. GORDY ALAM, MD
Gastroenterology (Digestive Diseases)

Patient Name:_____Date of Birth:_____

REVIEW OF SYSTEMS

Check any that may apply: no selection signifies "no"

GENERAL

[ ] Fever [ ] Fatigue [ ] Weakness [ ] Weight loss/gain

EYES, EARS, NOSE AND THROAT

[ ] Eyeglasses, contacts [ ] Blurred vision [ ] Glaucoma
[ ] Sore throat [ ] Allergies/Sinus problems [ ] Hearing loss

HEART

[ ] Chest Pain [ ] Swollen feet, legs [ ] Heart murmur [ ] Heart rhythm problems

LUNGS

[ ] Chronic cough [ ] Coughing up blood [ ] Shortness of breath [ ] Asthma/wheezing

GENETOURINARY

[ ] Difficulty urinating [ ] Urinating more than twice a night [ ] Blood in urine
[ ] Leakage of urine [ ] Trouble starting or holding urine [ ] Difficulty with erection

MUSCULOSKELETAL

[ ] Joint pain/swelling [ ] Back pain [ ] Muscle pain

SKIN

[ ] Rash [ ] Itching [ ] Skin Cancer

NEUROLOGICAL

[ ] Headaches [ ] Seizures [ ] Strokes/Numbness

PSYCHIATRIC

[ ] Memory loss [ ] Depression [ ] Confusion

ENDOCRINE (Glands)

[ ] Heat/Cold Intolerance [ ] Excessive Thirst/Urination

HEMATOLOGICAL

[ ] Anemia [ ] Blood Transfusion

Reviewed:_____Date_____

T. GORDY ALAM, MD
Gastroenterology (Digestive Diseases)

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I GIVE MY AUTHORIZATION TO RELEASE MY PROTECTIVE HEALTH INFORMATION, INCLUDING RESULTS OF MY LABORATORY RESULTS, MRI, CT, COLONOSCOPY, EGD, PATHOLOGY AND OTHER RESULTS TO THE FOLLOWING DESIGNATED REPRESENTATIVE(S):

PATIENT INITIALS REPRESENTATIVE NAME

_____MY SPOUSE _____

_____MY CHILD _____

_____OTHER _____

□ **MAY NOT BE GIVEN TO ANYONE BUT MYSELF**

RESULTS/REMINDERS ARE TO BE LEFT: (PLEASE CHECK ONE OR ALL THAT APPLY)

- □ BY CELL PHONE/TEXT AT #_____
- □ BY HOME PHONE AT #_____
- □ BY EMAIL AT _____
- □ CAN LEAVE DETAILED VOICEMAILS

_____

PATIENT SIGNATURE DATE

AS A PATIENT, YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION OR, IF APPLICABLE, DURING A CONTESTABILITY PERIOD. IN ORDER FOR THE REVOCATION OF THIS AUTHORIZATION TO BE EFFECTIVE THE CLINIC MUST RECEIVE THE REVOCATION IN WRITING. THE REVOCATION MUST INCLUDE 1) PATIENTS NAME, ADDRESS, AND DATE OF BIRTH 2) THE PATIENTS DESIRE TO REVOKE THE AUTHORIZATION 3) THE DATE OF THE REVOCATION AND THE PATIENTS SIGNATURE. ALL REVOCATIONS MUST BE SENT IN WRITING TO THE ATTENTION OF DR. T. GORDY ALAM AT 17521 ST. LUKE'S WAY SUITE 190, THE WOODLANDS, TX 77384 OR FAX TO 844-202-3967 AND WILL NOT BE CONSIDERED EFFECTIVE UNTIL REVIEWED BY THE CLINIC.

Are you being seen today for abnormal test results (bloodwork, CT scan, ultrasound, etc.) that we need to obtain prior to your visit with the physician?

YES/NO/I BROUGHT MY OWN COPY

Date/approximate date of test:_____
Location of test:_____
Ordering provider of test:_____

T. GORDY ALAM, MD
Gastroenterology (Digestive Diseases)

PROCEDURE CANCELLATION POLICY

The service charge for the cancellation, failure to keep an appointment or rescheduling of a scheduled **procedure** is $150.00. This is because there is a multidisciplinary team (Anesthesiologist, Endoscopy Technician and Gastroenterologist) involved. Please make every effort to notify this office within 48 hours of your scheduled procedure if you must cancel or reschedule. This is how much time is needed to schedule another patient into that appointment time. I have read and understood the financial policy of this medical office and agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice without prior written notice.

Disclosure of Financial Interest

The providers of Gastroenterology Specialists of North Houston may refer you or take you to other facilities for treatments/procedures and or testing which these providers may have vested interest or earn profit from them. These facilities are independent from Gastroenterology Specialists of North Houston.

Patient/Responsible Party Signature: _____

Printed Name: _____

Date:_____

PHARMACY INFORMATION

Pharmacy Name:_____
City:_____
Phone:_____

Prescription History Consent YES/ NO
(SEE BELOW)

I voluntarily consent to provide GSNH access to and use of my prescription history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years. I acknowledge that GSNH may use health information exchange systems to electronically transmit, receive and/or access my prescription history.
I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from GSNH unless revoked by me in writing. I certify that I have read this form or it has been read to me.