

Today's Date _____ Date of Last Office Visit _____

Name _____ Age _____ Date of Birth _____

Primary Care Physician _____ Referring Physician _____

1) Describe the reason(s) for your visit today _____

2) Preferred Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____
Street Suite # City State Zip

I authorize Atlanta Gastroenterology Associates to obtain my prescription history electronically. Yes No

3) Provide details regarding current and/or past use of the following:

Alcohol (beer, wine, liquor) Never Former Current (Every Day) Current (Some Days) Current (Unknown)

I.V. or Recreational Drugs Never Former Current (Every Day) Current (Some Days) Current (Unknown)

Tobacco (cigarettes, cigars, chewing tobacco) Never Former Current (Every Day) Current (Some Days) Current (Unknown)

Have you ever had any of the following vaccines? Influenza (Flu) Hepatitis A Hepatitis B
 Other _____

4) Are you currently taking blood thinners (such as Coumadin®, Eliquis®, heparin, Plavix®, Pradaxa®, Xarelto®)? Yes No

Are you currently taking aspirin/NSAIDs (Ibuprofen, Advil®, Aleve®, BC Powder®, Goody's Powder®, Naprosyn®)? Yes No

List Current Medications (including herbal) and Dosage

List any medications you have stopped taking since your last visit _____

List any allergies _____

Do you need a new prescription or refill? If so, list medication and supply needed.

5) Are you experiencing any of the following symptoms? If so, please describe.

	Yes	No		Yes	No
Constitutional			Heart Racing/Skipping	<input type="checkbox"/>	<input type="checkbox"/>
Body Aches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory		
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Wheezing or Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

Description of above problem _____

6) Have you had any of the following since your last visit? If so, please briefly describe and list date of service.

	Yes	No	
Colonoscopy/Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emergency Room Visit(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____
Labs or other blood work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgeries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ultrasounds	<input type="checkbox"/>	<input type="checkbox"/>	_____
X-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Signature _____ Date _____

Physician Signature _____ Date _____

AGA, LLC d/b/a Atlanta Gastroenterology Associates ("AGA") and its affiliated companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. AGA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AGA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, etc.)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, ask to speak to the site manager.

If you believe that AGA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: AGA, LLC, ATTN: Compliance Officer, 550 Peachtree St NE, Ste 1600, Atlanta, GA 30308, (phone) 404.888.7575, (fax) 404.253.6896, or (email) hipaacompliance@atlantagastro.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1.800.368.1019, 800.537.7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

AGA offers language services free of charge to those patients requiring assistance.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

ማስታወሻ: የግንኙነት ቋንቋ አማርኛ ከሆነ የትርጉም አገልግሎት ድርጅቶቻችን በነጻ ሊያገኙዎት ተዘጋጅተዋል።

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。