PERSONAL HISTORY
ESTABLISHED PATIENT

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

List any allergies ____________

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

List Current Medications (including herbal) and Dosage

____________ ____________
____________ ____________
____________ ____________

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

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

____

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

	Yes	No		Yes	No
Abdominal Pain	❑	❑	Difficulty Swallowing	❑	❑
Anal/Rectal Pain or Itching	❑	❑	Heartburn/Esophageal Reflux	❑	❑
Black Stool	❑	❑	Indigestion	❑	❑
Bloating/Belching/Gaseousness	❑	❑	Nausea/Vomiting	❑	❑
Change in Bowel Habits	❑	❑	Rectal Bleeding	❑	❑
Constipation	❑	❑	Unintentional Weight Loss	❑	❑
Diarrhea	❑	❑	Other ____________		

Description of Above Problem ____________

5) 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	❑	❑	____________
Emergency Room Visit(s)	❑	❑	____________
Hospitalizations	❑	❑	____________
Labs or other blood work	❑	❑	____________
Surgeries	❑	❑	____________
Ultrasounds	❑	❑	____________
X-rays	❑	❑	____________
Other tests	❑	❑	____________

6) List any questions or concerns you have for your physician today.

____
____

Parent / Legal Guardian Signature ____________ Date ____________

Physician Signature ____________ Date ____________

ATLANTA Gastroenterology ASSOCIATES

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS AND NONDISCRIMINATION STATEMENT: DISCRIMINATION IS AGAINST THE LAW

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: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡

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。