ROOM: _____ FOR OFFICE USE ONLY

WT:_____ P:_____ S NS FS

_____ HT:_____ BP:_____/_____

Elias Fanous, Jr., M.D., P.A. F/U Sheet

(copyright pending)

Your name: _____ Today's date: _____

Address:_____

Preferred Pharmacy: _____

Your phone #: _____ Main reason you're here: _____

Cell #: _____ How long has it bothered you? _____

Date of birth: _____ Your age _____ Who is your primary doctor? _____

Social Security # : _____ Who sent you to see us? _____

Please list each medication you take, include the dosage and how long you have been taking them:

_____

Drug Allergies? _____

Circle "yes" or "no" to every question

Dysphagia

Food sticks when I swallow yes no

If yes, how many times per week?_____

I sometimes retch/vomit to free solid food yes no

Water often sticks when I swallow yes no

I often have pain with swallowing yes no

Reflux

Do you have reflux despite medication? yes no

If yes, how many times per week? _____

Acid/sour/bitter/burning in or up chest yes no

Easily relieved with antacids yes no

Are you on prescription acid medication? yes no

If yes, circle one: Nexium Prevacid Aciphex Dexilant Pantoprazole Prilosec Omeprazole

Has your heart been evaluated recently yes no

Nausea/Vomiting

I often have nausea (queasy) yes no

If yes, how many times per week? _____

Is it **better** or **worse** with food (circle one)

My nausea is caused by my medicines yes no

My nausea has no rhyme or reason yes no

Do you vomit? yes no

If yes, how many times per week? _____

I vomit liquid only yes no

I vomit undigested or digested food yes no

Dyspepsia

I often have bothersome gas/belching yes no

I have bloating/distension that is NEW yes no

I recently feel full with only a few bites yes no

Constitutional Symptoms/Liver

Are you losing weight? yes no

Are you dieting or trying to lose weight? yes no

I often have fever over 100 degrees? yes no

How much weight lost in 3 months? _____

I currently have hepatitis B or C (circle) yes no

If on treatment, how many weeks? _____

Circle "yes" or "no" to every question

Abdominal Pain

My stomach often hurts yes no

Circle how severe: None 1 2 3 4 5 6 7 8 9 10(very severe)

If yes, how many times per week? _____

Is it sharp/burning or dull/aching/pressure (circle one)

Is it constant or off & on? (circle one)

Does it travel to your back? yes no

Does it wake you from sleep? yes no

Does it ever last more than one hour? yes no

Is it **better** or **worse** with food? (circle one)

What makes it better? _____

What makes it worse? _____

Colon

Has your Gallbladder been removed? yes no

Have you ever had colon polyps? yes no

Last time you had a colonoscopy _____

Colon polyps/cancer in any blood relative? yes no

If yes, circle: brother sister mom dad child aunt/uncle cousin grandparent

Do you have diverticulosis or diverticulitis yes no

Bowel Changes

Often constipated?(# days without bm:_____) yes no

I often have diarrhea (times per day:_____) yes no

I take laxatives (times per week____:_____) yes no

I have seen blood in my stool yes no

My stool has been black and tarry yes no

I take iron or pepto bismol (if yes, circle one) yes no

Blood on the **toilet paper** or **in the bowl** ? yes no

Bowels move urgently after eating yes no

#BMs per day:_____ #BMs per week:_____

My stool has changed in shape or caliber yes no

Do you soil yourself? yes no

Do you use any tobacco or nicotine products? Yes no

(circle one) cigarettes cigar dip e-cigarettes

Do you use illegal drugs? yes no

Do you drink beer, wine, or liquor? yes no

PLEASE LIST ANYONE WE HAVE PERMISSION TO SPEAK WITH REGARDING YOUR MEDICAL CARE: _____

_____

PATIENTS ACKNOWLEDGEMENT FORM

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

1. I understand that I am financially responsible for my health insurance deductible coinsurance or non-covered service.

2. Co-payments are due at time of service.

3. In the event that my health plan determines a service to be **"not payable",** I will be responsible for the complete charge and agree to pay the cost of all services provided.

4. If I am uninsured, I agree to pay for all the medical services rendered to me at of service

NOTICE OF CANCELLATION POLICY:

1. If you need to cancel or reschedule your office visit appointment for any reason, you must give at least **24 hours notice**. Any follow-up office appointment not canceled **with at least 24 hours notice** will result in a **$40 charge**. New patient appointments will incur a **$75 charge**.
   (Not showing up for your appointment is the same as canceling your appointment.)

2. Any procedures not canceled with **48 business hours** will result in a **$325 charge**.
   (Not showing up for your appointment is the same as canceling your appointment.)

3. Any patient who **reschedules or cancels 3 appointments** without proper notice (listed above) will be **dismissed** from Dr. Fanous' care.
4.

I consent to provision of services by a mid-level provider (Nurse Practitioner Aric Barrios) under the direction of the physician (Elias Fanous, M.D.)

_____ _____

Signature of Responsible Party **Date**

_____

Printed Name