Paul J. Spinka M.D.
Gastroenterology and Hepatology
1839 Sonoma Street
Redding, CA 96001
Phone (530)244-0654 Fax (530)244-0698

Dear ____

You have an appointment scheduled with us on:

Date:_________________________________Time:_______________________

You will find a medical history form and patient demographics information form attached. Please fill out these forms prior to your appointment and bring it with you to your appointment. This will help in expediting your registration as well as to direct the use of your appointment time more appropriately. All information provided will be kept confidential.

Please also bring with you your insurance cards and picture ID.
Your copay, co-insurance and/or deductible will be due at the time of visit.

We would also like to mention our appointment cancellation policy. At least a 24 hour notice is requested. Failure to do so may require the need to be re-referred to the practice.

Respectfully Yours,

Paul J. Spinka M.D.

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PLEASE FILL OUT THE FOLLOWING INFORMATION. YOU WILL NEED TO PROVIDE A COPY OF YOUR INSURANCE CARD AND A PHOTO I.D. AT THE TIME OF YOUR APPOINTMENT.

NAME: ____
FIRST MIDDLE LAST

MAILING ADDRESS____
PO BOX/ STREET CITY STATE ZIP

PHONE: ____
PRIMARY/HOME SECONDARY/CELL/WORK

DATE OF BIRTH:__________________SOCIAL SECURITY #:__________________MARITAL STATUS________________

EMAIL ADDRESS:____
Check your email for a link from Practice Fusion that will connect you with your medical records online.

PATIENTS EMPLOYER/OCCUPATION:____

EMPLOYERS ADDRESS____
STREET CITY STATE ZIP

SPOUSE OR GUARDIAN NAME ____PHONE___________________

EMERGENCY CONTACT____PHONE___________________

REFERRING DOCTOR____

ETHINICITY:______NON-HISPANIC ________HISPANIC
PREFERRED LANGUAGE:_______________________
RACE:_____CAUCASIAN/ EUROPEAN AMERICAN
_____ AFRICAN AMERICAN
_____ ASIAN AMERICAN
_____ NATIVE AMERICAN/NATIVE ALASKAN
_____ NATIVE HAWIIAN/ OTHER PACIFIC ISLANDER
_____ OTHER RACE

DO YOU AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO ANYONE OTHER THAN YOUR INSURANCE COMPANY?_________YES _______________NO
IF YES, PLEASE LIST NAME AND RELATIONSHIP ____

I hereby give lifetime authorization for payment of Insurance and/or Medicare benefits to be made directly to Dr. Paul Spinka for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize this healthcare provider to release information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGNATURE____DATE______________________

Name:____

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Please fill out the health questionnaire and bring with you to your appointment. This questionnaire may seem long, but filling it out will allow the doctor to be much more thorough. Please mark each question by circling "yes" or "no". If you are uncertain how to answer, please place a question mark (?) after it. Please fill in the blanks or write "none" or "n/a" for not applicable. Brief notes may be written in the margin.

Chief Complaint: in a few words list the major reasons you are being seen in this office. If more than one, list in order of importance. (Will be discussed in detail at your appointment)

____
____

Past History: List all significant illnesses, injuries, hospitalizations and surgeries.

____
____
____

Have you specifically had or been told to have any of the following:

Diverticulosis	Yes	No
Colitis	Yes	No
Colon Polyps	Yes	No
Rheumatic Fever	Yes	No
Hepatitis / Jaundice	Yes	No
Hemochromatosis	Yes	No
Cancer__________	Yes	No
Ulcers	Yes	No

Medications: What medication are you currently taking? Please include herbs and over the counter meds. Include the dosage and frequency that you're taking. Attach a list if needed.

1.______________________________ 4. ______________________________
2.______________________________ 5.______________________________
3.______________________________ 6.______________________________

Allergies: Are you allergic to any medications? (Please list meds and reactions to each):

____

____

Family History:

	If living: Health status	If deceased: age of death and cause
Father	___________	____________
Mother	___________	____________
Brother/Sister	___________	____________
	___________	____________
Son/ daughter	___________	____________

Have any blood relatives ever had:			List Whom:
Colon polyps	Yes	No	______________________
Colitis	Yes	No	______________________
Crohn's	Yes	No	______________________
Cancer of the Bowel	Yes	No	______________________
Cancer of the Uterus, Cervix or Breast	Yes	No	______________________
Cancer __________	Yes	No	______________________
Liver Disorder	Yes	No	______________________
Hepatitis/Cirrhosis	Yes	No	______________________
Alcoholism	Yes	No	______________________
Diabetes	Yes	No	______________________
Bleeding Tendency	Yes	No	______________________
Heart Disease	Yes	No	______________________
High Blood Pressure	Yes	No	______________________

Social History:

Years of Education	Grammar	High School	College
Circle one	1 2 3 4 5 6 7 8	1 2 3 4	1 2 3 4

Do you drink coffee, tea, cola?	Yes	No	How much?_________________
Do you smoke?	Yes	No	How much?_________________
Have you ever smoked?	Yes	No	How much?_________________
Do you Drink Alcohol?	Yes	No	How much?_________________

Did you ever drink considerably more than listed above? Yes No

Have you had fevers in the past three months? Yes No

Have you had weight change in the last year? Yes No How much?__________

Head:

Eye disease or injury	Yes	No
Headaches	Yes	No
Dry mouth	Yes	No
Dry or itching eyes	Yes	No
Loss of vision	Yes	No
Nosebleeds	Yes	No
Hearing loss	Yes	No

Respiratory:

Coughing up blood Yes No

Chronic cough Yes No

How many blocks can you walk without having to catch your breath?________

Skin test for tuberculosis Yes No

if yes, year and results _____________

Year of last chest x-ray___________________

Cardiovascular:		
Chest Pain	Yes	No
Shortness of breath	Yes	No
when lying flat	Yes	No
Ankle/leg swelling	Yes	No
Rapid, hard or skipped heartbeats	Yes	No

Gastrointestinal:		
Change in appetite	Yes	No
Heartburn/Indigestion	Yes	No
Nausea/Vomiting	Yes	No
Trouble swallowing	Yes	No
Black bowel movements	Yes	No
Abdominal pain/Cramping	Yes	No
Constipation/ Diarrhea	Yes	No

Genitourinary:		
Burning/painful urination	Yes	No
Blood in urine	Yes	No

Neurophysiology:		
Dizziness or unconsciousness	Yes	No
Seizures or convulsions	Yes	No
Numbness/tingling/paralysis	Yes	No
Have you ever been advised to be under psychiatric care	Yes	No

Musculoskeletal:		
Pain in calves or buttocks When walking	Yes	No

Skin:		
Unusual hair loss	Yes	No
Rash/ skin changes	Yes	No

Hematological:		
Anemia	Yes	No
Received blood transfusion	Yes	No
Abnormal bruising or bleeding	Yes	No

Date of last Colonoscopy/ Sigmoidoscopy:________________________

For Female Patients:
Date of last period: ______________________
Menopause : Yes No
Number of pregnancies _________
Date of last Pap smear__________Normal Yes No
Date of last breast exam_________Normal Yes No
Date of last Mammogram________Normal Yes No

Referred By_____________________________Family Doctor_______________________

Patient's Signature __________________________Date ____________________________

PHYSICIAN TO FILL OUT THIS PORTION

Weight ________kg______lbs
Height _________
BP____________ _________
Sitting standing

GEN
SKIN
HEENT
NECK
LUNGS
COR
EXT
NEURO
RECTAL

ABDOMEN:

LABS:

ASSESSMENT:

PLAN: