DIGESTIVE DISEASE ASSOCIATES OF ROCKLAND, PC

974 Rte 45
Pomona, NY 10970
(845) 354-3700 * fax (845) 354-5439

Dear Patient:

As you are aware, there are very strict governmental mandated rules concerning patient confidentiality and release of a patient's medical information. Therefore, in our continuing efforts to improve patient/physician communications, DDAR can offer you additional ways to receive information, with your signed authorization, concerning your care and treatment.

PART I:

If there is any FAMILY MEMBER OR FRIEND whom we may discuss or release information on your behalf, please list them here: ☐ **No one**

Name	Relationship

I understand that I may revoke or change this authorization at any time in writing.

_____ _____

Signature **Date**

_____

Print Name

PART II:

If you would like to authorize us to receive information/results from any other physician, health care provider, radiology group or laboratory, please check or list them here:

☐ **None**

Please use blank lines for "other"

☐ MRI (Any Site)	☐ Quest Laboratories	☐ Good Samaritan Hospt
☐ Ramapo Radiology	☐ Rockland MediLabs	☐ Nyack Hospital
☐ Rockland Diagnostics	☐ LabCorp	☐ _____
☐ Ramapo Diagnostics	☐ _____	☐ _____
☐ _____	☐ _____	☐ _____

I understand that I may revoke or change this authorization at any time in writing.

_____ _____

Signature **Date**

_____

Print Name

Patient Name: _____ Age _____ Date _____

Reason for this visit: _____ Height _____ Weight _____

Please list any past medical problems or injuries you have had: _____

Please list any past surgical problems and describe any operations you have had: _____

Operations:	Year	Hospital
1.		
2.		
3.		

Please list any drugs you are allergic to:

1. _____ 2. _____ 3. _____ 4. _____

Have you had an anesthesia reaction? Yes No If so, when and please describe: _____

Have you had previous gastroscopy? Yes No Colonoscopy? Yes No CT Scan? Yes No

UGI series? Yes No Barium Enema? Yes No Sonogram? Yes No

If so, when, and where? _____

What were the results? _____

Please list all current medications. Drugs (include aspirin) and Herbal Medicines.

Do you have any cardiac condition, such as mitral valve prolapse, requiring antibiotics for dental work? Yes No

Do you have any bleeding tendencies? Yes No

Do you smoke? Yes No If yes, how many? _____

Have you had any of the following? Please mark the appropriate box with an "X":

	Yes	No		Yes	No
High blood pressure			Stomach ulcer		
Low blood pressure			Loss of weight		
Blood transfusion			Loss of appetite		
Heart trouble			Belching, heartburn		
Chest pain			Black, tarry stools		
Shortness of breath			Urinary difficulty		
Palpitations			Kidney stone		
Recent cardiac problems			Urine infection		
Please explain:			Frequent urination		
Jaundice			Date of last gynecological exam		
Abdominal pain			Abnormal vaginal bleeding		
Chronic cough			Phlebitis		
Nausea			Arthritis		
Vomiting			Pain in extremities		
Diarrhea			Family history of colon polyps or colon cancer		
Constipation			Family history of peptic ulcer		
Rectal pain or bleeding			Hemorrhoid trouble		
Recent change in bowel habits			Number of bowel movements per day		
Alcohol abuse			Pancreatitis		
IV drug use			Other family history of cancer		

PLEASE USE THE BACK OF THIS SHEET FOR ANY ADDITIONAL INFORMATION OR COMMENTS WHICH YOU FEEL MIGHT BE OF INTEREST.

Patient Signature: _____ Date: _____

MD Signature: _____ Date: _____

MD Comments: _____

Additional Information:

Date	Reviewed By	Changes Since Last Review