

SANJAY T. BHAT, M.D.
Board-certified Gastroenterologist
314-729-1717

BHATGI.COM

Date: _____ Primary Care Doctor: _____

Other doctors you see: _____

Who referred you(circle one): Primary doctor Insurance Our patient Self

Have you seen Dr. Bhat before? (circle one): YES NO

REASON FOR VISIT: _____

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Age: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone () _____

Cell Phone () _____

Male: _____ Female: _____ Social Security#: _____

Single: _____ Married: _____ Separated: _____ Widowed: _____ Divorced: _____

Current Occupation/Employer _____

Office Phone () _____ Address: _____

City: _____ State: _____ Zip: _____

What kind of work? _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse or significant other phone number: () _____

Do You Have a Co-Pay? _____ Amount? _____

Pharmacy: _____ Phone: () _____

Friend or Relative Not Living With You: _____ Phone:() _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby give Dr. Sanjay Bhat my consent for treatment and agree to let Sanjay T. Bhat, MD, PC to release my records to my insurance company for reimbursement purposes.

X _____ Date: _____

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR INSURANCE CARD(S) AS WELL AS A PICTURE ID (IF AVAILABLE) ALONG WITH THIS COMPLETED FORM!

Do you have any of the following symptoms?(circle all that apply)

- | | |
|-----------------------|---|
| Nausea | Diarrhea |
| Heartburn | Liver problems |
| Loss of appetite | Pancreas problems |
| Vomiting | Abnormal labs or tests (told by doctor) |
| Vomiting blood | Abdominal bloating |
| Swallowing difficulty | Jaundice/Hepatitis |
| Weight loss | Blood in stools |
| Constipation | |

Abdominal pain:

How long? _____

Where? (above or below belly button) _____

Type (circle all that apply)? Sharp Dull Burning Discomfort

What makes it worse? _____

What makes it better? _____

Personal History

Do you or have you ever had

- | | | | |
|-------------------------|--------------|--|--------------|
| 1. Menstrual Difficulty | Yes___ No___ | 16. Skin Disease | Yes___ No___ |
| 2. Migraines | Yes___ No___ | 17. Breast Disease | Yes___ No___ |
| 3. Dizziness | Yes___ No___ | 18. Sexually Transmitted Disease | |
| 4. Ear Problems | Yes___ No___ | | Yes___ No___ |
| 5. Glaucoma | Yes___ No___ | 19. Gout or Arthritis | Yes___ No___ |
| 6. Epilepsy/Convulsions | Yes___ No___ | 20. Joint Disease | Yes___ No___ |
| 7. Thyroid Disorder | Yes___ No___ | 21. Stroke | Yes___ No___ |
| 8. Diabetes | Yes___ No___ | 22. Pace Maker | Yes___ No___ |
| 9. Asthma | Yes___ No___ | 23. Defibrillator in Chest | Yes___ No___ |
| 10. Emphysema | Yes___ No___ | 24. Any other medical problems we should know about? | |
| 11. Tuberculosis | Yes___ No___ | | _____ |
| 12. Heart Disease | Yes___ No___ | | _____ |
| 13. High Blood Pressure | Yes___ No___ | | |
| 14. Kidney Infection | Yes___ No___ | | |
| 15. Kidney Stones | Yes___ No___ | | |

List All Operations (what was done and what year)

X-Rays

Have You Ever Had Any of the Following?

1. Upper GI Series Yes___ No___ When?_____
2. Barium Enema Yes___ No___ When?_____
3. Gall Bladder X-Ray Yes___ No___ When?_____
4. CT scan of abdomen Yes___ No___ When?_____

Allergies:

Medications:(list over the counter medications, herbal supplements, vitamins also)

Social history:

Do You Smoke? _____ How many packs a day? _____

For how many years? _____

Do you drink alcohol? _____ How many drinks per day? _____ Per week? _____

Per month? _____

What Do You Normally Eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Family History:

Father... Age _____ Health Status: _____

Mother... Age _____ Health Status: _____

Sisters... Age _____ Health Status: _____

Brothers... Age _____ Health Status: _____

Any Family History of the Following:

Diabetes _____

High Blood Pressure _____

Cancer (who and what kind) _____

I have reviewed the History as documented above and personally noted the Chief Complaint and HPI.

DR. BHAT'S SIGNATURE

DATE