



DIGESTIVE HEALTH CONSULTANTS
Of Northern California

RICHARD AULD, MD
R. LOGAN FAUST, MD, FACG
SAHAR GHASSEMI, MD
PAUL HORNBERGER, MD
SUMIT KOHLI, MD
A. MICHAEL LUSTBERG, MD

1210 Sonoma Avenue
Santa Rosa, CA. 95405
Tel: 707.544.5093
Fax: 707.528.8444

Dear Patient,

At the request of your physician, an appointment has been scheduled for you here in our office. Because we appreciate the value of your time, we ask you to please consider the following suggestions to make your visit as convenient and productive as possible.

- Please complete the enclosed health questionnaire paying particular attention to your current medications and doses. Bring it with you at the time of your appointment.
- Please bring your health insurance card.
- Please bring with you any records that you feel may be pertinent. If you have had recent blood testing or x-rays performed, let the receptionist know so that we may obtain a copy at the time of your appointment.

We look forward to being of service to you. **If you are unable to keep this appointment, please call the office at 544-5093 as soon as possible so that the appointment time may be used by another patient.**

Sincerely,

The Physicians of Digestive Health Associates of Northern California

DIGESTIVE HEALTH CONSULTANTS OF NORTHERN CALIFORNIA

RICHARD AULD, MD, R. LOGAN FAUST, MD, FACG, SAHAR GHASSEMI, MD, PAUL HORNBERGER, MD, A. MICHAEL LUSTBERG, MD, SUMIT KOHLI, MD

1210 Sonoma Ave., Santa Rosa, CA. 95405

Telephone: (707) 544-5093

Fax: (707) 528-8444

PATIENT INFORMATION

Mr./Mrs./Ms./Dr. _____
(First) (Middle) (Last)

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

Telephone Numbers: Home: _____ Work: _____ E-Mail: _____

Social Security #: _____ Birth date: _____ Age: _____

Employer: _____ Address: _____ Occupation: _____

Marital Status: **S M D W** Spouse's Name: _____

In Case of Emergency Notify: _____ Telephone: _____ Relationship: _____

You were referred by? _____ And your primary MD is? _____

MD Telephone # _____

Do you give our office permission to leave a telephone answering machine message regarding:

| | | |
|---|-----|----|
| Confirming or scheduling appointments? | YES | NO |
| Laboratory, X-ray, and/or Procedure results | YES | NO |

INSURANCE INFORMATION

Primary Insurance: _____ Claims Address: _____

ID# _____ Group# (if applicable) _____

Secondary Insurance: _____ Claims Address: _____

ID# _____ Group# (if applicable) _____

Is the insurance in your name? **Y N** If Not—Subscriber Name: _____

SSN: _____ Date of Birth: _____ Relationship: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES: Your signature below acknowledges that you have received a copy of our office's "Notice of Privacy Practices". This notice describes how medical information about you can be used and disclosed and how you can get access to this information.

Signature: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS: Please read the following and consent by signing below:

I directly assign all medical/surgical benefits from third party payers to Drs. Faust, Lustberg, Jayaraman and/or Staples and I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize my doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be as valid as the original.

Signature: _____ Date: _____

DIGESTIVE HEALTH CONSULTANTS OF NORTHERN CALIFORNIA

RICHARD AULD, MD, R. LOGAN FAUST, MD, SAHAR GASSEHMI, MD, PAUL HORNBERGER, MD, SUMIT KOHLI, MD, A. MICHAEL LUSTBERG, MD
1210 Sonoma Ave., Suite B Santa Rosa, CA. 95405

Telephone: (707) 544-5093

Fax: (707) 528-8444

MEDICAL HISTORY -- Please fill out all three pages, thank you.

1. Your Name: _____ Today's Date _____

2. Referring Physician _____ Other Doctors involved _____

3. Reason for your visit _____

4. List all medications you are currently taking (include any over-the-counter medications and nutritional supplements). Please include the dosage (milligrams, grams, tbsp., tsp., etc) and how often you take them.

| | Medicine | Dosage | Frequency | | Medicine | Dosage | Frequency |
|----|----------|--------|-----------|----|----------|--------|-----------|
| 1. | | | | 5. | | | |
| 2. | | | | 6. | | | |
| 3. | | | | 7. | | | |
| 4. | | | | 8. | | | |

5. DO YOU HAVE ANY ALLERGIES OR SENSITIVITIES TO MEDICATIONS OR LATEX? YES NO
explain here: _____

6. Do you take products containing aspirin or related medications? (ibuprofen, Advil, Aleve, Alka-Seltzer, Anacin, Bufferin, Excedrin, Midol, Motrin, Naprosyn, other arthritis medication, etc.) _____

7. What is your approximate weight now? ____ One year ago? ____ Five years ago? ____ Height _____

8. Do you now have or have you ever had:

| | yes | no | year of onset |
|--------------------------|------------|-----------|----------------------|
| Hypertension | () | () | _____ |
| Diabetes | () | () | _____ |
| Heart disease | () | () | _____ |
| Asthma | () | () | _____ |
| Emphysema or COPD | () | () | _____ |
| Hepatitis/Jaundice | () | () | _____ |
| Colitis/Crohn's | () | () | _____ |
| Stroke/TIA | () | () | _____ |
| Problems with Anesthesia | () | () | _____ |
| Sleep Apnea | () | () | _____ |
| Other: _____ | | | _____ |

9. Please list all prior surgeries you have had:

| | Year of surgery | Type of surgery | Hospital | City |
|----|-----------------|-----------------|----------|------|
| A. | | | | |
| B. | | | | |
| C. | | | | |
| D. | | | | |
| E. | | | | |
| F. | | | | |

9. COLORECTAL CANCER SCREENING: (circle or fill in the blank)

- Have you ever had a sigmoidoscopy, colonoscopy, or barium enema (lower GI)? **SIG COLON BE NONE**
When? _____ What was the result? **NORMAL OTHER** _____

NAME: _____

10. Do you smoke cigarettes? **YES NO** If yes, approximately how much do you smoke per day? _____
If you have quit smoking, when did you quit? _____ How many years have you/did you smoke? _____

11. How many drinks of alcohol do you consume in an average 7 day period of time? (Please count all alcoholic drinks, including beer and wine.) _____

12. How many cups of coffee do you drink per day, on the average? _____

13. Have you ever received a blood transfusion? **YES NO** If yes, when? _____

14. Occupation (if retired; prior occupation) _____
Any Toxic Exposures? _____

15. FAMILY HISTORY

| | IF LIVING Age and Health Problems | IF DECEASED Cause of Death |
|----------------|--------------------------------------|-------------------------------|
| Father | _____ | _____ |
| Mother | _____ | _____ |
| Spouse | _____ | _____ |
| Brother/Sister | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| Children | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

16. Have any of your close blood relatives ever had stomach cancer, colon cancer, other cancers, celiac disease, heart disease, blood disorders, hemophilia, liver disease, hepatitis, ulcers, or inflammatory bowel disease?

A. _____

B. _____

C. _____

D. _____

If you have any further comments or any particular concerns that you would like to discuss at your appointment, please list them below (or continue on the back of this page, if necessary).

Please complete the final page that follows. Your time and effort completing this form will allow us to provide you with more complete and personalized care. Thank you!

NAME: _____

Review of Systems

| SYMPTOM | YES | NO | DETAILS |
|----------------------------|-----|----|---------|
| Fever | | | |
| Fatigue/Weakness | | | |
| Weight loss | | | |
| Weight gain | | | |
| Chills | | | |
| Sweats | | | |
| Loss of appetite | | | |
| Sleep disorder | | | |
| Nausea | | | |
| Vomiting | | | |
| Diarrhea | | | |
| Constipation | | | |
| Abdominal pain | | | |
| Abdominal bloating | | | |
| Rectal pain | | | |
| Blood in stool | | | |
| Black stool | | | |
| Change in bowel habit | | | |
| Trouble swallowing | | | |
| Indigestion | | | |
| Reflux | | | |
| Vomiting | | | |
| Chest pain | | | |
| Palpitations | | | |
| Swelling | | | |
| Cough | | | |
| Wheezing | | | |
| Shortness of breath | | | |
| Food allergies | | | |
| Rash | | | |
| Itching | | | |
| Yellow skin/eyes | | | |
| Pain with urination | | | |
| Blood in urine | | | |
| Urine incontinence | | | |
| Eye pain | | | |
| Double vision | | | |
| Hearing loss | | | |
| Sore throat | | | |
| Hoarseness | | | |
| Sinus drainage | | | |
| Nosebleeds | | | |
| Heat/Cold intolerance | | | |
| Excessive thirst/urination | | | |
| Abnormal bruising | | | |
| Anemia | | | |
| Back pain | | | |
| Joint pain | | | |
| Headache | | | |
| Weakness | | | |
| Depression | | | |
| Anxiety | | | |



DIGESTIVE HEALTH CONSULTANTS
Of Northern California

RICHARD AULD, MD
R. LOGAN FAUST, MD, FACG
SAHAR GHASSEMI, MD
PAUL HORNBERGER, MD
SUMIT KOHLI, MD
A. MICHAEL LUSTBERG, MD

1210 Sonoma Avenue
Santa Rosa, CA. 95405
Tel: 707.544.5093
Fax: 707.528.8444

PATIENT INFORMED CONSENT

PROCEDURE: **COLONOSCOPY**, WITH BIOPSY IF INDICATED, AND/OR POLYPECTOMY IF INDICATED, AND/OR HEMORRHAGE CONTROL IF INDICATED, AND/OR DILATATION OF A STRICTURE IF INDICATED.

Colonoscopy is a procedure where a flexible small diameter tube is passed up into your rectum (or into a colostomy), and then advanced throughout your large intestine (colon). The instrument uses video technology to produce an image of your intestine as the instrument is moved about. In this manner, the entire large intestine can be carefully inspected by your physician. Abnormalities in the colon such as polyps, areas of inflammation or ulceration, diverticuli, or tumors can be identified. When indicated, therapeutic maneuvers can also be employed, such as biopsy or polypectomy (removal of polyps).

During the procedure, you will be given medication intravenously (through one of the veins in your hand or arm). This will prevent you from having significant discomfort during the examination.

Common reasons for performing colonoscopy include screening for colon cancer, rectal bleeding, stool tests positive for blood, inflammatory bowel disease (Crohn's or Ulcerative Colitis), previous history of colon polyps or colon cancer, abnormalities seen on a barium enema, and unexplained chronic diarrhea.

Alternatives to colonoscopy include a barium enema (BE) or CT colonography . These are x-ray procedures where barium is passed up into your rectum (BE) or a "CAT" scanner is used to make a picture of the colon. You may have already had these performed. Neither however is as accurate as colonoscopy in revealing lesions in the colon, such as polyps or inflammation. Also, therapeutic maneuvers such as biopsy, polypectomy, hemorrhage control, or dilatation of narrowed areas (strictures) are not possible with these xray procedures. To perform therapeutic maneuvers on the colon, surgery is generally the only alternative method to colonoscopy.

Colonoscopy is a routine medical procedure, which is generally safe. As with all medical procedures, complications can occur. Perforation of the colon is very uncommon, but if it were to occur, would likely require emergency surgical repair. Bleeding, infection, low blood pressure, a slowing of the heart rate or breathing and reactions to the medications given are also uncommon, but could potentially occur.

Colonoscopy is highly accurate, but not perfect, and it is possible that an abnormality, even cancer, could be overlooked.

Colonoscopy is most commonly performed on an outpatient basis. However, due to the medications you will receive during the examination, it is essential that you not drive an automobile or operate other dangerous machinery for the remainder of the day following the procedure. You will therefore need to arrange transportation to and from the outpatient center. Most likely, you will be able to eat normally after the procedure. You should be able to resume any normal activities the next day.

If you have any questions regarding the procedure, or if you would desire any further explanation regarding any aspects of the procedure, you are encouraged to discuss this with either the staff or the physician.

I have read the above explanation, and I am satisfied with the information I have received, or I have obtained further details regarding the nature of the procedure, its indications, possible benefits, possible risks, or alternatives.

DATE PATIENT'S SIGNATURE DATE WITNESS' SIGNATURE



DIGESTIVE HEALTH CONSULTANTS
Of Northern California

RICHARD AULD, MD
R. LOGAN FAUST, MD, FACG
SAHAR GHASSEMI, MD
PAUL HORNBERGER, MD
SUMIT KOHLI, MD
A. MICHAEL LUSTBERG, MD

1210 Sonoma Avenue
Santa Rosa, CA. 95405
Tel: 707.544.5093
Fax: 707.528.8444

Dear Patient:

If you have a biopsy performed during your endoscopy procedure, the specimen(s) will be sent either to Dianon Laboratories or to Wilber & Associates Pathology for diagnostic evaluation. From Dianon you will receive a single bill. From Wilber & Associates you receive a bill from both the physicians and from Memorial hospital.

For your convenience these charges will be billed to your insurance company. Dianon, Wilber and Associates and Santa Rosa Memorial Hospital accept almost all insurance plans. Discounted pricing is available for patients not covered by insurance and you may contact the number on your billing statement if you would like additional information about this or if you have questions regarding the charges.

Sincerely,

Digestive Health Consultants of Northern California