AGA

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES, INC.

TO ALL PRIVATE INSURANCE RECIPIENTS
KNOW & UNDERSTAND YOUR WELLNESS BENEFITS
WITH REGARD TO COLONOSCOPIES

Please be aware that some private insurance companies are offering "Wellness Screening" programs for colonoscopies. As gastroenterologists, we see this as a great benefit for our patients; yet, your health insurance carrier may have certain criteria that must be followed for reimbursements to be paid at 100%.

The first thing that patients need to understand when using the "Wellness Screening" program is that not all of you will fall into a "screening" code. Please understand that a "screening" code is to be used for patients without any symptoms or complaints. The "screening code" has its own criteria. For example, the patient must not have any symptoms or complaints, they are to be at least 50 years old, have a family history if less than age 50, etc. For those patients with some type of symptom or complaint, we are to use the code that matches that particular symptom/complaint. **Therefore, we cannot randomly use screening codes on all of our new patients.** This also goes against our ethics.

Please understand that we will be happy to do as much as we can so that your insurer will reimburse our fees at 100%; yet, you, the patient, must understand that we have certain protocols that we must follow regarding coding. As you may feel it easy to use the screening code, all of our documentation would have to imply strictly screening.

Also, it must be understood that your insurance carrier may not cover office visits and pathology charges with a screening code.

Therefore, please know and understand your insurance benefits. Also, please understand that we, the physicians, will do all that we can so that your benefits will be paid at 100%. We believe if insurance carriers will allow wellness programs, then they should clarify all the elements of how this benefit is to be reimbursed not only for the patient but also for all the doctors and facilities that are utilized in connection with these charges.

Sincerely,

Joseph D. Hollier, M.D.
John A. Kirkikis, M.D.

AGA

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES, INC.

So we may efficiently serve you when you arrive for your appointment, please take a few minutes of your time to fill out the attached forms. Please bring the forms, your insurance cards, your driver's license (or any picture identification) and a list of your medications you are currently taking with you on the day of your appointment. ***PLEASE MAKE SURE THAT ON THE DAY OF YOUR APPOINTMENT WE HAVE ANY LAB AND X-RAY REPORTS THAT WERE DONE BY YOUR REFERRING PHYSICIAN.**

Charges for your initial office visit can range between $70.00 and $320.00 depending on the type of service provided. This amount is payable at the time of your visit. If you are a member of a participating PPO insurance carrier, or if you have Medicare/Medicaid; any co-payments, coinsurance, and/or deductible amounts will be payable at the time of your visit.

Your appointment is scheduled for _____.

AGA

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES, INC.

Joseph D. Hollier, MD
John A. Kirkikis, MD
Sarah J. Griffin, PA-C

301 4th Street
Suite 1-A
Alexandria, LA 71301
(318) 473-8188

Mailing Address:
Box 30146
301 4th Street
Alexandria, LA 71301

PATIENT PORTAL ADDRESS: https://mycw6.eclinicalweb.com/jhmd/jsp/login.jsp

This letter is designed to answer questions you may have regarding your medical care. Our medical staff, receptionists, secretaries, and nursing personnel operate as a team. We take great pride in our training, knowledge and capabilities, and we are dedicated to giving you quality care.

LOCATION

We are located on the 1st floor of the Medical Terrace building at the old hospital entrance.

OFFICE HOURS

Regular office hours are 8:00 a.m. to 4:30 p.m. Monday through Friday. We will try to see you at the scheduled time. We believe strongly in the value of your time and will do our best to keep you from having to wait for a long time. On occasion, emergencies can cause problems and whenever possible, you will be fully informed if there will be any delays. We would appreciate 24 hour notice if you find it necessary to cancel your appointment. During the week, each doctor is in the hospital ¾ of the time and is in the office **only** ¼ of the time.

TELEPHONE CALLS

Our telephones are answered from 8:00 a.m. to 4:30 p.m. Our employees have been instructed to handle all incoming calls. This allows the doctors to attend to their scheduled patients with a minimum of interruptions during office hours. If you find it necessary to contact a doctor after the hours designated above, our phone service will forward the message to the nurse on call. At the earliest possible convenience the nurse will return the call.

PRESCRIPTIONS AND REFILLS

Just as we cannot treat illnesses over the telephone, we cannot prescribe medications over the telephone. Medication refills will only be handled during regular office hours and **only** if you are currently under our care. If you need a prescription refill, have the name and/or number of the medication, the pharmacy telephone number, and the dosage schedule handy when you call. Please call before 2:00 p.m. for your refills. Any calls after this time will be handled the following day. Because of our office schedule, calls to the pharmacies for refills are made in the late afternoon.

FEES AND PAYMENT

We make every effort to keep the cost of your medical care to a minimum. You can help by paying at the time of your visit. This is expected unless prior financial arrangements have been made.

INSURANCE

We try to simplify the preparation of insurance claims, thereby holding down the costs which are unrelated to the delivery of good medical care. Our office will file your insurance for all hospital admissions or outpatient procedures. For those who have Medicare insurance, we do accept assignment and will file all charges including office visits. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, coinsurance, or any balance not paid for by your insurance company. We know questions can arise on insurance matters and these should be discussed with our insurance clerk. We will be happy to help you receive maximum benefits; however, the agreement of the insurance company to pay for medical care is a contract between you and your insurance company.

The best health care is based on friendly mutual understanding among staff, doctor, and patient. We are looking forward to getting to know you!

PATIENT CARE

AGA is a specialty clinic specializing in gastroenterology and hepatology. All of our patients are received through a physician referral. Our patients are either referred for routine colon cancer screening or gastroenterology/hepatology disorders. We will do the appropriate studies such as endoscopy and tests. **The patient, then will be referred back to the primary physician with our results and plan of care.** For the patient with liver disease, inflammatory bowel disease, or Barrett's esophagus, we will continue to follow these patients in our established patient clinics.

Revised 10/29/12

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

How do you plan to pay for this visit? Cash/Check_____ Visa/Mastercard_____ Insurance _____

Do you have a Medical Power of Attorney? ❑ Yes ❑ No Do you have a Living Will? ❑ Yes ❑ No

*****PLEASE PRINT*****

PATIENT_____ DATE OF BIRTH_____ AGE_____

ADDRESS_____ CITY/STATE_____ ZIP _____

SOCIAL SECURITY #_____ MARITAL STATUS: S / M / D / W GENDER: Male / Female

HOME #_____ WORK #_____ CELL # _____

YOUR EMAIL ADDRESS FOR **PATIENT PORTAL ACCESS** _____

RACE (circle one): African American Hispanic Caucasian Other: _____ REFUSED TO REPORT

ETHNICITY (circle one): Non-Hispanic Hispanic Other:_____ REFUSED TO REPORT

LANGUAGE: English Spanish Sign Language Other: _____

EMPLOYED BY_____ OCCUPATION _____

SPOUSE_____ EMPLOYED BY_____ WK # _____

RESPONSIBLE PARTY (if different from above) _____

ADDRESS _____

EMPLOYED BY_____ PHONE # _____

EMERGENCY CONTACT (other than spouse or parent) _____

REFERRED BY _____ PHARMACY YOU USE_____

INSURANCE INFORMATION

1. PRIMARY INSURANCE CO._____ PHONE # _____

ADDRESS _____

POLICY OR I.D.#_____ GROUP # _____

SUBSCRIBER_____ SUBSCRIBER DOB_____

2. SECONDARY INSURANCE CO._____ PHONE #_____

ADDRESS _____

POLICY OR I.D. #_____ GROUP# _____

SUBSCRIBER _____ SUBSCRIBER DOB _____

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

REQUIRED SIGNATURES

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION (ALL INSURANCES):

I request that payment of authorized insurance benefits be made on my behalf to Alexandria Gastroenterology Associates for any services furnished. I authorize any holder of medical information about me to be released to the insurance carrier and its agents to determine benefits payable for related services. I also request that payment for authorized Medigap/Secondary insurance carrier benefits be made on my behalf to Alexandria Gastroenterology Associates I authorize any holder of medical information about me be released to the Medigap/Secondary insurance carrier and it's agents to determine benefits payable for related services. I understand that I do not need to provide my Medigap/Secondary insurance carrier with information concerning Medicare claims because my signing of this authorization will allow Medicare payment information to cross-over automatically.

Signature:_____ **Date**_____

ALL PATIENTS (REQUIRED):

I understand that as a courtesy Alexandria Gastroenterology Associates will bill my insurance carrier for services rendered. I understand that I am financially responsible and agree to all charges for myself and for the members of my family, as applicable, promptly upon presentation thereof.
Charges as shown by statements are agreed to be correct unless protested in writing within thirty days of date of service. It is agreed that payments will not be delayed or withheld because of any insurance coverage of the pendency of claims thereon. In the event legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney's fees and other such costs as determined by the court.

Signature:_____ **Date**_____

CONSENT TO OBTAIN EXTERNAL Rx HISTORY:

I _____ whose signature appears below, authorize Alexandria Gastroenterology Associates and its affiliated providers to view my external prescription history via the RxHub services. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Signature:_____ **Date**_____

ACKNOWLEDGEMENT OF HIPAA:

I _____ whose signature appears below, have the right to review the Notice of Privacy Practices prior to signing this consent. **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists, Cardiac and Vascular Services of Cenla and Alexandria Gastroenterology Associates** reserve the right to revise their Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Kerrie Basco, 1587 North Bolton Ave., Suite 1100, Alexandria, LA 71303.

Signature:_____ **Date**_____

Release Form for Individuals Involved in Care of Patient

I, give Dr. Hollier or Kimberly Sills, FNP-C permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from A. G. A.

[ ] NONE. My medical records are not to be released to anyone.

This consent is valid until such time as I provide A. G. A. written revocation of it.

Dr. Hollier or Kimberly Sills, FNP-C may speak with:

Name:_____
Relationship: _____
Phone:_____

Name:_____
Relationship: _____
Phone:_____

Name:_____
Relationship: _____
Phone:_____

Name:_____
Relationship: _____
Phone:_____

Name:_____
Relationship: _____
Phone:_____

** This form is to be filed in the patient's medical record.

Revised 06/06/17

NAME_____DATE

Pharmacy Information
Name of Pharmacy:
Location:
Rx ID#

Name_____ Date_____

Complaint: (Symptom, Onset, Progression)

_____

_____

_____

Please enter the approximate year of any of the illnesses you may have had and the treating physician or medical facility.

Illness	Year	Dr/Hosp	Illness	Year	Dr/Hosp
Peptic ulcers			Thyroid Problem		
Diverticulosis			Endocrine Disorder		
Crohn's			Cancer & Type		
Colitis			Anemia		
Ulcerative Colitis			Bleeding Tendency		
Hepatitis			Kidney Disease		
Pancreatitis			Kidney Stone		
Liver Disease			Prostate Trouble		
Hemorrhoids			Stroke		
High Blood Pressure			Arthritis		
Heart Attack			Gout		
Heart Murmur			Eye Disorder		
Other Heart Condition			Venereal Disease		
Poor Circulation			Herpes		
Bronchitis			AIDS		
Asthma			Diabetes		
Pneumonia			Other		
Tuberculosis					

Please list approximate year of any surgery you may have had.

Appendectomy_____ Colectomy _____ Hysterectomy (part/comp) _____

Gallbladder _____ Stomach Surgery _____ Other Surgeries_____

Please list all medications you are now taking, including birth control pills and those you buy without a doctor's prescription (i.e. aspirin, cold tablets, etc). List name, dosage, times per day.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list any drug allergies.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Please give the following family history:

Relative:	Age if living	Age at death	Liver Disease	Peptic Disease	Gallbladder	Irritable Bowel	Hypertension	Heart Disease	Stroke	Diabetes	Cancer & Type	Blood Disease	Lung Disease	Tuberculosis	Kidney Disease	Mental Problems	Colon Polyps	Liver Disease, Cirrhosis	Cause of Death/Comment
Father																			
Mother																			
Brother																			
Brother																			
Sister																			
Sister																			
Spouse																			
Child																			
Child																			

Please give a brief description of your job and daily activities (if retired, please state former occupation):

_____

_____

Have you had a recent tick, flea, mite, or any other pest or animal bite or scratch? If so, please describe:

_____

Have you traveled out of the country in the past two years? If so, please indicate where:

_____

What are your hobbies?_____

Do you exercise?_____

How much coffee or tea do you usually drink?_____ cups per day.

Have you ever used "street drugs"?_____ If so, please describe below:

_____

INSTRUCTION: Please check "yes" or "no".

Yes ___No ___ 1) Do you have any **difficulty swallowing** or do you get food lodged in your throat? (If you answered YES, please complete the following. If you answered NO, please go to number 2.)

Yes ___No ___ a. Does **food lodge** in the back of your mouth?

Yes ___No ___ b. Do liquids pass up your nose?

Yes ___No ___ c. Do **solids (meat)** get stuck in your throat (esophagus) and requires vomiting to release?

Yes ___No ___ d. Do you have frequent **heartburn?** (one episode nearly everyday)

e. How long have your symptoms existed?_____

f. How frequently do your symptoms occur?
(daily, weekly, monthly, other_____)

Yes ___No ___ g. Do your symptoms occur equally with **liquids** as well as with solids?

Yes ___No ___ 2) Do you have any problems with **liver disease** or recent hepatitis? (If you answered YES, please complete the following. If you answered NO, please go to number 3.)

a. When were you first noted to have the problem?_____

Yes ___No ___ b. Have you ever had **Hepatitis A**?

Yes ___No ___ c. Have you ever had **Hepatitis B**?

Yes ___No ___ d. Have you ever had **Hepatitis C**?

Yes ___No ___ e. Have you ever had the hepatitis vaccine?

Yes ___No ___ f. Have you ever received blood products? When_____

Yes ___No ___ g. Do you eat **raw shellfish**?

Yes ___No ___ h. In the past 5 years, have you had more than one **sexual partner**?

Yes ___No ___ i. Have you had any problems with **gallbladder disease**?

Yes ___No ___ j. Do you have any **family members** with liver disease?

Yes ___No ___ 3) Are you experiencing **rectal bleeding**? (If you answered YES, please complete the following. If you answered NO, please go to number 4.)

Yes ___No ___ a. Is the blood **black** or your stools loose?

Yes ___No ___ b. Is the blood **bright red** and surrounds normal stool?

c. How much blood with each movement? (Circle one)
(less than a tablespoon, a tablespoon,1/2 cup, more than 1 cup)

Yes ___No ___ d. Do you have **diverticulosis**?

Yes ___No ___ e. Has the **caliber** (size) and shape of your stool changed?

Yes ___No ___ f. Have you ever been found with **colon polyps** or **colon cancer**?

Yes ___No ___ 4) Are you experiencing **abdominal pain**? (If you answered YES, please complete the following. If you answered NO, please go to number 5.)

Yes ___No ___ a. Is the pain located in your upper abdomen under your **breastbone**?

Yes ___No ___ b. Do you have any radiation of your pain to your **back**?

c. Is your pain a dull, persistent pressure, or burning discomfort? (Circle one).

Yes ___No ___ d. Are you experiencing a lot of **heartburn**?

Yes ___No ___ e. Is your pain a **sharp pain** lasting for several hours and relieved only to return again either later that day or the next day?

Yes ___No ___ f. Is your pain exaggerated **(worse) after eating**?

Yes ___No ___ g. Are you experiencing nausea with **vomiting**?

Revised 10/27/08

h. Are there factors which relieve your pain? circle/write (antacids, medication _____,etc._____)

Yes ___No ___ i. Is the pain located in your **lower abdomen**?

Yes ___No ___ j. Is your pain worse **prior to defecation** and/or relieved after a bowel movement?

Yes ___No ___ 5) Are you experiencing any changes in your **bowel habits**?(constipation or diarrhea). (If you answered YES, please complete the following. If you answered NO, please go to number 6.)

Yes ___No ___ a. Are you having loose, **watery stools**?

b. How long have you had diarrhea?_____.

c. How many loose stools per day do you have?_____

Yes ___No ___ d. Is the **amount** of diarrhea related to how much you eat? (i.e., **fasting** will stop your diarrhea)

Yes ___No ___ e. Does your diarrhea stool **always float** in the toilet and is hard to flush?

Yes ___No ___ f. Have you noticed a frequent film of **oil** in the toilet after movements?

Yes ___No ___ g. Is your diarrhea **intermittent** with period of normal stools?

Yes ___No ___ h. Does your diarrhea **alternate** with constipation? (i.e., hard stools followed with diarrhea).

Yes ___No ___ i. Are you having difficulty with **hard stools**?

Yes ___No ___ j. Are your stools small and **pellet-like**?

Yes ___No ___ k. Do you drink plenty of **water** (i.e., greater than 6 glasses per day.)

l. Are you using **fiber supplements**? Name_____

m. Do you use **laxatives** like Ex-Lax? Name_____

Yes ___No ___ 6) Have you ever had an UGI series? (Date_____)

Yes ___No ___ 7) Have you ever had a gastroscopy/EGD? (Date_____)

Yes ___No ___ 8) Have you ever had a barium enema? (Date_____)

Yes ___No ___ 9) Have you ever had a colonoscopy? (Date_____)

Yes ___No ___ 10) Have you ever had an ultrasound or CT scan? (Date_____)

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weight loss Yes___No___ 11) Has your **weight changed** in the past 3 months?

fever Yes___No___ 12) Are you having a **fever**?

chills, sweats Yes___No___ 13) Are you having night **sweats or chills**?

adenopathy Yes___No___ 14) Do you have any **enlarged glands**?

fatigue Yes___No___ 15) Do you feel **tired** or weak?

headaches Yes___No___ 16) Do you have frequent **headaches**?

blurry vision Yes___No___ 17) Do you have **trouble with your eyes**? (Blurriness, spots, irritation)

glasses Yes___No___ 18) Do you wear **glasses or contacts**?

tinnitus Yes___No___ 19) Do you have **trouble with your ears**? (Deafness, ringing, discharge)

motion sickness Yes___No___ 20) Do you have any **motion sickness** or dizziness?

epistaxis Yes___No___ 21) Do you have **nose bleeds**?

hoarseness Yes___No___ 22) Are you experiencing **hoarseness**?

colds Yes___No___ 23) Do you have head **colds** or runny nose?

URI Yes___No___ 24) Do you have any **allergies**? _____

oral prob. Yes___No___ 25) Do you have any problems with your teeth, gums, mouth or tongue?

dentures Yes___No___ 26) Do you have any **dentures**?

olfactory Yes___No___ 27) Have you noticed any change in **smell/taste**?

HTN	Yes___No___	28)	Do you have **high blood pressure**?
chest pain	Yes___No___	29)	While exercising, do you have **chest pain**?
leg cramps	Yes___No___	30)	Do you get **leg or thigh cramps** while walking?
palpitations	Yes___No___	31)	Do you feel your **heart racing** too fast?
irreg. HB	Yes___No___	32)	Does your heart beat too slow or irregular?
syncope	Yes___No___	33)	Have you felt **light-headed** or passed out?
edema	Yes___No___	34)	Do you have **swelling** of your ankles?
murmurs	Yes___No___	35)	Do you have any **heart murmurs**?
venous insuf.	Yes___No___	36)	Do you have **varicose veins** or leg vein clots?
Reynaud's	Yes___No___	37)	Any blue color to fingers or toes?
PND	Yes___No___	38)	Do you use two pillows to rest better?
	Yes___No___	39)	Do you sit up at night to breathe easier?
	Yes___No___	40)	Do you have difficulty breathing with **light activities**?
cough	Yes___No___	41)	Do you have **early morning** cough?
	Yes___No___	42)	Do you have a cough that **persists** all day?
	Yes___No___	43)	Are you coughing up **sputum**?
	Yes___No___	44)	Are you coughing up **blood**?
bronchitis	Yes___No___	45)	Do you have wheezing or bronchitis episodes?
	Yes___No___	46)	Have you ever had an EKG? (Date_____)
	Yes___No___	47)	Have you ever had a chest x-ray? (Date_____)
	Yes___No___	48)	Have you ever had a TB skin test? (Date_____)

	Yes___No___	49)	Have you had a recent bladder or **kidney problem**?
Dysuria	Yes___No___	50)	Are you having **burning** with urination?
frequency	Yes___No___	51)	Are you urinating more **frequently**?
Nocturia	Yes___No___	52)	Do you get up at **night** to urinate?
hesitancy	Yes___No___	53)	Is it hard to start your urine flow?
hematuria	Yes___No___	54)	Has your urine been **bloody** or dark-colored?
	Yes___No___	55)	Do you leak urine when laughing or coughing?
UTI	Yes___No___	56)	Have you been treated recently for **bladder infection**?
Stones	Yes___No___	57)	Have you had kidney **stones**?
	Yes___No___	58)	Have you had a recent urinalysis? (Date_____)

FOR MALES ONLY

	Yes___No___	59)	Have you had recent **prostate trouble**?
	Yes___No___	60)	Any sore or swelling of penis or testicles?

FOR FEMALES ONLY (MALES GO TO # 70)

	Yes___No___	61)	What was your age at start of menstruation?____
	Yes___No___	62)	What was the date of last menstruation?_____
	Yes___No___	63)	Are your cycles abnormal or **irregular**?
	Yes___No___	64)	Is your menstruation **heavy**?
	Yes___No___	65)	Do you have any problems with discharge or **infection**?
	Yes___No___	66)	Do you take **birth control pills**?
	Yes___No___	67)	Do you take **hormones**?
	Yes___No___	68)	Do you have any breast **lumps**, discharge, pain, etc.?
	Yes___No___	69)	Have you had a **mammogram**? (Date_____)

temp. tolerance	Yes___No___	70)	Do you always feel **warmer** than those around?
	Yes___No___	71)	Do you always feel **cooler** than those around?
	Yes___No___	72)	Do you have **hot flashes**?
thyroid disease	Yes___No___	73)	Have you ever had a **goiter**?
	Yes___No___	74)	Have you had **thyroid problems**?
	Yes___No___	75)	Do you have excessive **thirst**?
anemia	Yes___No___	76)	Have you ever been **anemic**?
bleeding	Yes___No___	77)	Do you have any **bleeding problems** with deep cuts or after surgery?
bruising	Yes___No___	78)	Do you have any problems with **bruising**?
blood transfusion	Yes___No___	79)	Have you received any **blood transfusions**?
rheum. disease	Yes___No___	80)	Do you have any **deformities** of back, arms, legs?
back injury	Yes___No___	81)	Have you had any **back injuries**?
joint	Yes___No___	82)	Do you have **joint pain**, swelling, or stiffness?
skin disease	Yes___No___	83)	Do you have any skin or **rash** problems?
moles	Yes___No___	84)	Do you have any **moles** that have changed in color or size?
	Yes___No___	85)	Do you get **cold sores** or fever blisters?
CNS	Yes___No___	86)	Have you had a **stroke**?
	Yes___No___	87)	Does any part of your body get **numb**?
	Yes___No___	88)	Have you ever had **seizures**?
	Yes___No___	89)	Do you have a problem with **coordination**?
mental	Yes___No___	90)	Do you have unusual **memory loss**?
	Yes___No___	91)	Do you feel **nervous** or anxious?
	Yes___No___	92)	Do you feel **depressed** or sad?
	Yes___No___	93)	Have you had any changes in **sleep pattern**?

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

TOBACCO CONTROL

NAME_____ **DATE** _____

ARE YOU A:

- ❑ CURRENT SMOKER
- ❑ FORMER SMOKER
- ❑ NEVER SMOKER

IF 'CURRENT SMOKER': HOW OFTEN DO YOU SMOKE CIGARETTES?

- ❑ EVERY DAY
- ❑ SOME DAYS, BUT NOT EVERY DAY

IF 'CURRENT SMOKER': HOW MANY CIGARETTES A DAY DO YOU SMOKE?

- ❑ 5 OR LESS
- ❑ 6-10
- ❑ 11-20
- ❑ 21-30
- ❑ 31 OR MORE

IF 'CURRENT SMOKER': HOW SOON AFTER YOU WAKE UP DO YOU SMOKE YOUR FIRST CIGARETTE?

- ❑ WITHIN 5 MIN.
- ❑ 6-30 MIN.
- ❑ 31-60 MIN.
- ❑ AFTER 60 MIN.

IF 'CURRENT SMOKER': ARE YOU INTERESTED IN QUITTING?

- ❑ READY TO QUIT
- ❑ THINKING ABOUT QUITTING
- ❑ NOT READY TO QUIT

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

ALCOHOL MISUSE/ABUSE (AUDIT C)

NAME_____ **GENDER:**_____ **DATE** _____

DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?

- ❑ YES
- ❑ NO

IF 'YES': HOW OFTEN DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?

- ❑ NEVER (0 POINTS)
- ❑ MONTHLY OR LESS (1 POINT)
- ❑ TWO TO FOUR TIMES A MONTH (2 POINTS)
- ❑ TWO TO THREE TIMES PER WEEK (3 POINTS)
- ❑ FOUR OR MORE TIMES A WEEK (4 POINTS)

IF 'YES': HOW MANY DRINKS DID YOU HAVE ON A TYPICAL DAY WHEN YOU WERE DRINKING IN THE PAST YEAR?

- ❑ 1 OR 2 (0 POINTS)
- ❑ 3 OR 4 (1 POINT)
- ❑ 5 OR 6 (2 POINTS)
- ❑ 7 TO 9 (3 POINTS)
- ❑ 10 OR MORE (4 POINTS)

IF 'YES': HOW OFTEN DID YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION IN THE PAST YEAR?

- ❑ NEVER (0 POINTS)
- ❑ LESS THAN MONTHLY (1 POINT)
- ❑ MONTHLY (2 POINTS)
- ❑ WEEKLY (3 POINTS)
- ❑ DAILY OR ALMOST DAILY (4 POINTS)

INTERPRETATION

- ❑ POSITIVE
- ❑ NEGATIVE

INTERPRETATION

THE AUDIT-C IS SCORED ON A SCALE OF 0-12 (SCORES OF 0 REFLECT NO ALCOHOL USE).

- IN MEN, A SCORE OF 4 OR MORE IS CONSIDERED POSITIVE.
- IN WOMEN, A SCORE OF 3 OR MORE IS CONSIDERED POSITIVE.