ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

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; however, your health insurance carrier may have certain criteria that must be followed for reimbursements to be paid at 100%.

When using the "Wellness Screening" program not all patients will fall into a "screening" code. Please understand that a "screening code" is to be used for patients without any symptoms/complaints, they are to be at least 45 years old, 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%; however, we have certain protocols that we must follow regarding coding. As you may feel it would be easy to use the screening code, all of our documentation would have to imply strictly screening.

Please also keep in mind your insurance carrier may not cover office visits and/or pathology charges with a screening code.

Therefore, we ask that you know and understand your insurance benefits, and 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.

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

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 due at the time of your visit. If you are a member of a participating PPO insurance carrier, or if you have Medicare/Medicaid; any copayments, coinsurance, and/or deductible amounts will be due at the time of your visit.

Your appointment is scheduled for _____

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

Joseph D. Hollier, MD **Kimberly Sills, FNP**	**1587 N. Bolton Avenue** **Suite 1100** **Alexandria, LA 71303** **(318) 473-8188**	**Mailing Address** **1587 N. Bolton Avenue** **Suite 1100** **Alexandria, LA 71303**

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.

OFFICE HOURS

Regular office hours are 8:00 a.m. to 5:00 p.m. Monday through Thursday, Friday 8:00 a.m. to 12:00 noon. 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 48 hour notice if you find it necessary to cancel your appointment.

TELEPHONE CALLS

Our telephones are answered 8:00 a.m. to 5:00 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

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 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 PAYMEN

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.

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 will then be referred back to the primary physician with our results and plan of care.** For the patients with liver disease, inflammatory bowel disease, or Barrett's esophagus, we will continue to follow these patients in our established patient clinics.

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

Revised 2/14/2023

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: _____REFUSE TO REPORT

ETHINICITY (circle one): Non-Hispanic Hispanic Other: _____ REFUSE 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

PRIMARY INSURANCE CO._____PHONE #_____

ADDRESS_____

POLICY OR I.D.#_____ GROUP #_____

SUBSCRIBER_____SUBSCRIBER DOB_____

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 Medigap/Secondary insurance carrier and its agents to determine benefits 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 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 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 office manager, 1587 North Bolton Ave., Suite 1100, Alexandria, La 71303.

Signature: _____ Date _____

HIPAA Release Form for Individuals Involved in Care of Patient:

I, give Dr. Hollier and Kimberly Sills, FNP-C permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payments for health services that 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 and 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.**

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 Problems	_____	_____
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 Conditions	_____	_____	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 medication 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 of 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 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:

_____

NAME_____DATE_____

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 every day)

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**?

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 diarrhea movements 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. Is your diarrhea stool more **foul** smelling than before?

Yes□ No□ f. Does your diarrhea stool **always float** in the toilet and is hard to flush?

Yes□ No□ g. Have you noticed a frequent film of **oil** in the toilet after movements?

Yes□ No□ h. Is your diarrhea **intermittent** with period of normal stools?

Yes□ No□ i. Does your diarrhea **alternate** with constipation? (i.e., hard stools followed with diarrhea).

Yes□ No□ j. Are you having difficulty with **hard stools**?

Yes□ No□ k. Are your stools small and **pellet-like**?

Yes□ No□ l. Do you drink plenty of **water** (i.e., greater than 6 glasses per day.)

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

n. 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? (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_____)

wt. 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 wear **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_____)
Dysuria	Yes□	No□	49)	Have you had a recent bladder or **kidney problem**?
Frequency	Yes□	No□	50)	Are you having **burning** with urination?
Nocturia	Yes□	No□	51)	Are you urinating more **frequently**?
Hesitancy	Yes□	No□	52)	Do you get up at **night** to urinate?
Hematuria	Yes□	No□	53)	Is it hard to start your urine flow?
	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 (FEMALES GO TO #61)

	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**, discharges, pain, changes?
	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 bleeding bruising blood transfusion	Yes□	No□	76)	Have you ever been **anemic**?
	Yes□	No□	77)	Do you have any **bleeding problems** with deep cuts or after surgery?
	Yes□	No□	78)	Do you have any problems with **bruising**?
	Yes□	No□	79)	Have you received any **blood transfusions**?
rheum. disease back injury joint skin disease moles	Yes□	No□	80)	Do you have any **deformities** of back, arms, legs?
	Yes□	No□	81)	Have you had any **back injuries**?
	Yes□	No□	82)	Do you have **joint pain**, swelling, or stiffness?
	Yes□	No□	83)	Do you have any skin or **rash** problems?
	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**?

TOBACCO UTILIZATION

□NEVER USED		
□FORMER USER	□<1 MONTH □1-3 MONTHS □3-6 MONTHS □6-12 MONTHS □1-5 YEARS □5-10 YEARS □>10YRS	
□CURRENT USER	□DAILY □SPORADICALLY	□READY TO QUIT □ NOT QUITTING
	FIRST SMOKE IS _____ MINUTES UPON AWAKENING.	
	SMOKES PER DAY: □<5 □6-10 □11-20 □21-30 □≥31	

ALCOHOL CONSUMPTION

□NONE	□1-2 DAYS PER MONTH
□1-2 DAYS PER WEEK	□MOST DAYS
AVERAGE DAILY AMOUNT?	
□ 1-2 DRINKS □3-4 DRINKS	□5 -6 DRINKS □≥6 DRINKS