Patient Interview Form

First Name:	**Middle Initial:**		**Last Name:**
Address:	**City:**	**State:**	**Zip Code:**
Social Security #:	**Date of Birth:**	**Sex: (Please circle)** Male Female Other	**Marital Status: (Please circle)** Single Married Separated Divorced Widowed
Home Phone:	**Mobile Phone:**		**Personal email:**
Contact Preference: No preference Email Letter/phone Decline to specify Other: _____			
Patient Employer:	**Work#**		
Spouse's Name:	**Spouse's Date of Birth:**		**Spouse's SSN:**
Spouse's Employer:	**Spouse's Work #:**		**Spouse's Mobile #:**
Emergency Contact (other than spouse):	**Relationship:**		**Phone #:** **Mobile#:**
Physician you are seeing today:	**Referring Physician:**		**Reason for visit today:**
Race: (Please circle one) Black/African American White Asian American Indian/Alaska Native Decline to specify	**Ethnicity: (Please circle one)** Hispanic Not Hispanic or Latino Decline to specify		**Preferred Language: (Please circle one)** English Spanish/Castilian Decline to specify

***Please answer the following questions as accurately as possible. Your past medical history and your family history are used to determine what your insurance will cover for procedures. Inaccurate information can affect how your claim is paid. Please initial in the box after answering the questions.**

Have you ever had a colonoscopy? ☐ Yes ☐ No

If you have had a colonoscopy: When? _____
Where? _____

Have *you* ever had colon polyps? ☐ Yes ☐ No

Have *you* ever had colon cancer? ☐ Yes ☐ No

*** All questions in this box have been answered to the best of my knowledge.** _____ Initial

Has anyone in your *immediate family* ever had colon polyps? ☐ Yes ☐ No

If you answered *yes* to the question above, please circle which family member had *colon polyps*:

Mother Father Sister Brother Daughter Son

Has anyone in your *immediate family* ever had colon cancer? ☐ Yes ☐ No

If you answered *yes* to the question above, please circle which family member had *colon cancer*?

Mother Father Sister Brother Daughter Son

Gastroenterology Clinic, APMC - Endoscopy Center of Monroe, Inc.
Notice of Privacy Practices Acknowledgment

I, (patient name)_____ , acknowledge receipt of the Notice of Privacy Practices.
Signature:_____ Date: _____
Signature of Patient or Representative

I, (print name)_____ , certify that I have made a good faith effort to obtain written acknowledgment of the patient's receipt of the Notice of Privacy Practices, but the acknowledgment was not obtained because: _____
By:_____ Date:_____
Signature of Provider

Review of Systems/Current Symptoms: Please check yes or no

Cardio	Y	N	**Genitourinary**	Y	N	**Neurological**	Y	N
chest pain			dark urine			frequent headaches		
difficulty breathing with exercise			frequent urination			numbness or tingling		
irregular heart beat			painful urination			tremors		
palpitations			blood in urine			**Psychiatric**		
peripheral edema			urination during the night			anxiety		
Constitutional			hesitancy			depression		
fatigue			**Hematologic/Lymphatic**			difficulty sleeping		
fever			bleeding gums			panic attacks		
loss of appetite			easy bruising			**Respiratory**		
malaise			prolonged bleeding			cough		
sweats			palpable lymph nodes			difficulty breathing		
weight gain			**Integumentary**			wheezing		
weight loss			dryness					
ENMT			itching					
dizziness			jaundice					
nose bleeds			rashes					
sore throat			**Musculoskeletal**					
hearing loss			back pain					
ringing in ears			muscle weakness					
post nasal drip			stiffness					
hoarseness			Raynaud's disease					
halitosis (bad breath)								

Allergies: ☐ **No known allergies** ☐ **No known drug allergies**

☐ **Penicillin** ☐ **Sulfa** ☐ **Codeine** ☐ **Cephalosporins** ☐ **Erythromycin** ☐ **Eggs** ☐ **Peanuts** ☐ **Latex** ☐ **Soy**

Other Allergies: _____

Pharmacy: _____

Address **Phone**

Consent to Import Medication History

Do you consent to having your medications obtained that have been purchased at your pharmacy?

☐ **Yes** ☐ **No**

Current Medications: ☐ **None**

Name	**Dose**	**Frequency**

Immunizations: ☐ **None**

☐ **Flu vaccine** **When:**_____

☐ **Hepatitis B** **When:**_____

☐ **Hepatitis B-adult** **When:** _____

☐ **Tetanus toxoid** **When:** _____

☐ **Pneumonia** **When:** _____

Past or Present Medical Conditions

Gastrointestinal

	Y	N		Y	N		Y	N
Acid reflux			Cirrhosis			Colon polyp history		
Stomach ulcers			Primary biliary cirrhosis			Colon cancer		
Trouble swallowing			Fatty liver			Diverticulitis		
Gallstones			Hepatitis A			Diverticulosis		
Hiatal hernia			Hepatitis B			Irritable bowel disease		
Stomach cancer			Hepatitis C			Crohn's disease		
Helicobacter pylori			Abnormal liver tests			Ulcerative colitis		
Barrett's esophagus			Pancreatitis			Lactose intolerance		
Delayed gastric emptying			Celiac disease			Anemia		

Cardiovascular

	Y	N		Y	N		Y	N
Atrial fibrillation			Congestive heart failure			Stroke		
Deep vein thrombosis			Endocarditis			Ischemic heart disease		
High blood pressure			Transient Ischemic Attack (TIA)			Difficulty breathing with exercise		
Mitral valve prolapse			Coronary Artery Disease			Other:		
Carotid artery disease			Heart Attack					

Pulmonary/Other

	Y	N		Y	N		Y	N		Y	N
Asthma			Arthritis			Glaucoma			Cancer: Type-		
C.O.P.D.			Dementia			Renal insufficiency					
Emphysema			Chronic back pain			Sickle Cell trait					
HIV			Insulin dependent diabetes			Seizures					

Diagnostic Tests — Radiology Tests **(done in the past 6 months)**

GI Endoscopy	Y	N		Y	N		Y	N		Y	N
Flexible Sigmoidoscopy			EGD			Abdominal x-ray			HIDA scan		
Capsule endoscopy			Bravo ph study			Abdominal ultrasound			Sitzmarker colon transit study		
ERCP			Esophageal dilation			CT of the abdomen/Pelvis			MRCP		
PEG tube placement			Esophageal manometry			MRI of the abdomen/pelvis			Small bowel series		
Other:			Liver biopsy			Gallbladder ultrasound			Mammogram screening		

Previous Surgeries

	Y	N		Y	N		Y	N		Y	N
Gallbladder removed			Whipple procedure (pancreatic cancer)			Appendectomy			Heart valve		
Reflux surgery			Gastric bypass (Roux-en-Y)			Bladder suspension			Pacemaker		
Hiatal hernia repair			Colectomy-partial			C-section			Cardiac stents		
Gastric lap band			Total colectomy			Prostate surgery			Coronary artery bypass graft		
Small bowel resection			Colostomy			Hysterectomy			Total hip replacement		
Exploratory laparotomy			Hemorrhoidectomy			Mastectomy			Defibrillator		

Other surgeries: _____

Social History

Occupation: _____ Number of children: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Civil Union

Alcohol Use: ☐ **None**

	How much?	Frequency
☐ Beer		
☐ Wine		
☐ Liquor		

Tobacco Use: ☐ Never smoked ☐ Former smoker ☐ Current every day smoker ☐ Current, some day smoker ☐ Light smoker ☐ Heavy smoker ☐ Smoker, current status unknown

Type:	Started	Quit	Quantity	Frequency
☐ Cigarettes				
☐ Smokeless				
☐ Other				

Drug Use: ☐ **None**

Type:	Quantity	Frequency
☐ Currently uses IV drugs		
☐ Used IV drugs in the past		
☐ Currently uses recreational drug(s)		

Family Medical History: (This section pertains to your family, *not* your personal medical history)

	Y	N	If yes, who in your family?	Age of diagnosis
Crohn's disease				
Ulcerative colitis				
Celiac disease				
Liver disease				

	Alive	Deceased/At age:	Cause of death
Mother			
Father			
Brother			
Sister			
Daughter			
Son			

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities. ☐ **Yes** ☐ **No**

Reminder Preference

I would like to receive preventive care and follow up care reminders. ☐ **Yes** ☐ **No**

Patient Signature _____ **Date:** _____

Reviewed with: ☐ **Patient** ☐ **Parent** ☐ **Guardian** ☐ **Not Present**

Staff Signature: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of surgical and/or medical benefits directly to Gastroenterology Clinic, APMC (herein after GCM) and/or Endoscopy Center of Monroe, Inc. (herein after ECM) and further convey transfer and assign all of my rights in my insurance coverage to GCM and/or ECM for service rendered. I also hereby assign and transfer any and all rights, title, and interest to any claim for penalties and/or attorney fees arising under any state or federal law or regulation related to the payment of any claim for benefits to GCM and/or ECM. Regardless of the extent of the insurance coverage, I agree to be responsible for the entire balance. I also authorize release of information pertaining to my claim to my insurance company and/or companies or my attorney. Once the physician has obtained the patient's one-time authorization, he may submit any later claim on either an assigned or unassigned basis without obtaining any additional signature from the patient. In submitting claims, he should indicate "Patient request for payment on file." I hereby authorize GCM and ECM to furnish information to any requesting physician.

_____

Patient Signature Date

MEDICARE AUTHORIZATION

I certify that the information given to me in applying for a payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary of carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf once the physician has obtained the patient's one time authorization. He may submit any later Medicare claim on either an assigned or unassigned basis without obtaining any additional signature from the patient. In submitting claims, he should indicate "Patient request for payment on file." I hereby authorize Gastroenterology Clinic, APMC and/or Endoscopy Center of Monroe, Inc. to furnish information to any requesting physician.

_____

Patient Signature Date