Patient Interview Form

Patient Information:

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

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

Home Phone #: _____ Mobile #: _____ Work #: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Social Security #: _____ Patient's Employer: _____

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: _____

Emergency Contact Phone #: _____ Emergency Contact Mobile #: _____

Physician You Are Seeing Today: _____ Referring Physician: _____

Reason for your visit today: _____

Contact Preference

◯ Letter and/or phone

◯ Patient declines to specify

Email

Personal:_____

Race

Select one or more

◯ White ◯ Black or African American ◯ Asian ◯ American Indian or Alaska Native ◯ Native Hawaiian or Other Pacific Islander

◯ Unknown ◯ Patient declines to specify

Ethnicity

◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Patient declines to specify

Sex

◯ Male ◯ Female ◯ Other

Preferred Language

◯ English ◯ Spanish; Castilian ◯ Patient declines to specify Other:_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN	MEDICARE AUTHORIZATION
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/or ECM to furnish information to any requesting physician.	I certify that the information given by 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 or 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.
X Date:	X Date:

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

❒ I, (patient name) _____, acknowledge receipt of the Notice of Privacy Practices.

By: _____ Date: _____

Signature of Patient or Representative

❒ I, (provider) _____, 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

This document must be retained in the patient's chart for the longer of 6 years from the date of its creation or when it was last in effect.

Review Of Systems - **Mark symptoms you are having TODAY.**

Gastrointestinal

◯ None	Y	N
abdominal pain	◯	◯
bloating	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
gas	◯	◯
heartburn	◯	◯
jaundice	◯	◯
nausea	◯	◯
rectal bleeding	◯	◯
stomach cramps	◯	◯
vomiting	◯	◯
difficulty swallowing	◯	◯

Allergic/Immunologic

◯ None	Y	N
HIV exposure	◯	◯
persistent infections	◯	◯
strong allergic reactions or urticaria	◯	◯
watery, itchy eyes	◯	◯
frequent sneezing	◯	◯
chronic nasal congestion	◯	◯
chronic rhinorrhea	◯	◯

Cardiovascular

◯ None	Y	N
chest pain	◯	◯
dyspnea with exercise	◯	◯
irregular heart beat	◯	◯
palpitations	◯	◯
peripheral edema	◯	◯

Constitutional

◯ None	Y	N
fatigue	◯	◯
fever	◯	◯
loss of appetite	◯	◯
malaise	◯	◯
sweats	◯	◯
weight gain	◯	◯
weight loss	◯	◯
rigors	◯	◯

ENMT

◯ None	Y	N
difficulty swallowing	◯	◯
dizziness	◯	◯
ear pain	◯	◯
nasal obstruction	◯	◯
nose bleeds	◯	◯
sore throat	◯	◯
hearing loss	◯	◯
tinnitus	◯	◯
post nasal drip	◯	◯
hoarseness	◯	◯
halitosis	◯	◯

Endocrine

◯ None	Y	N
excessive thirst	◯	◯
hair loss	◯	◯
heat intolerance	◯	◯

Eyes

◯ None	Y	N
double vision	◯	◯
loss of vision	◯	◯
photophobia	◯	◯

Genitourinary

◯ None	Y	N
dark urine	◯	◯
decrease in urine flow	◯	◯
dysuria	◯	◯
frequent urinary infections	◯	◯
frequent urination	◯	◯
hematuria	◯	◯
impotence	◯	◯
nocturia	◯	◯
urethral discharge or incontinence	◯	◯
hesitancy	◯	◯

Hematologic/Lymphatic

◯ None	Y	N
bleeding gums or palpable lymph nodes	◯	◯
easy bruising	◯	◯
prolonged bleeding	◯	◯
adenopathy	◯	◯

Integumentary

◯ None	Y	N
allergies	◯	◯
dryness	◯	◯
hives	◯	◯
itching	◯	◯
jaundice	◯	◯
lesions	◯	◯
rashes	◯	◯

Musculoskeletal

◯ None	Y	N
arthritis	◯	◯
back pain	◯	◯
gout	◯	◯
joint deformity	◯	◯
joint pain	◯	◯
muscle weakness	◯	◯
stiffness	◯	◯
Raynaud's disease	◯	◯

Neurological

◯ None	Y	N
dizziness	◯	◯
fainting	◯	◯
frequent headaches	◯	◯
migraine	◯	◯
numbness or tingling	◯	◯
seizures	◯	◯
tremors	◯	◯
vertigo	◯	◯
memory loss	◯	◯

Psychiatric

◯ None	Y	N
anxiety	◯	◯
depression	◯	◯
difficulty sleeping	◯	◯
hallucinations	◯	◯
nervousness	◯	◯
panic attacks	◯	◯
paranoia	◯	◯

Respiratory

◯ None	Y	N
asthma	◯	◯
cough	◯	◯
dyspnea	◯	◯
excessive sputum	◯	◯
coughing up blood	◯	◯
shortness of breath with exercise	◯	◯
wheezing	◯	◯

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies

◯ Latex ◯ Eggs ◯ Soy ◯ Peanuts Other: _____

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

◯ Yes ◯ No

Pharmacy

Pharmacy Name | Address | Phone

Current Medications

☐ None

Name	Dose	How taken?

Past or Present Medical Conditions

GI

☐ None

☐ Acid Reflux ☐ Barrett's Esophagus ☐ celiac disease/sprue ☐ Cirrhosis
☐ Colon cancer ☐ Colon polyp history ☐ Crohn's Disease ☐ Diverticulosis
☐ abnormal liver tests ☐ Fatty Liver ☐ Gallstones ☐ Stomach cancer
☐ Slow emptying of the stomach/gastroparesis ☐ helicobacter pylori ☐ Hemorrhoids ☐ Hepatitis A
☐ Hepatitis B ☐ Hepatitis C ☐ Hiatal hernia ☐ Irritable Bowel Syndrome
☐ Iron Deficiency Anemia ☐ Lactose Intolerance ☐ Pancreatitis ☐ Primary Biliary Cirrhosis
☐ SJogrens Disease ☐ Ulcer Disease ☐ Ulcerative Colitis ☐ Diverticulitis

Other: _____

Cardiovascular

☐ None

☐ Atrial Fibrillation ☐ Carotid artery disease ☐ Coronary Artery Disease ☐ Deep vein thrombosis
☐ Endocarditis ☐ High blood pressure ☐ Congestive Heart Failure ☐ Heart Attack
☐ Stroke

Other: _____

Pulmonary

☐ None

☐ Asthma ☐ Emphysema ☐ C.O.P.D.

Other: _____

Other

☐ None

☐ Arthritis ☐ Back Pain (chronic) ☐ Diabetes Mellitus, Insulin Dependent ☐ Glaucoma
☐ Renal insufficiency ☐ Dementia ☐ HIV ☐ Seizures
☐ Sickle Cell Trait

Other: _____

Diagnostic Studies/Tests

GI Endoscopy

- [ ] None
- [ ] EGD — When:_____
- [ ] Bravo pH study — When:_____
- [ ] Colonoscopy — When:_____
- [ ] ERCP — When:_____
- [ ] Capsule Endoscopy — When:_____
- [ ] PEG tube placement — When:_____
- [ ] Double balloon small bowel endoscopy — When:_____
- [ ] EUS — When:_____
- [ ] Liver Biopsy — When:_____
- Other:_____

Radiology tests

- [ ] Gastric Emptying Study — When:_____
- [ ] HIDA / CCK Scan — When:_____
- [ ] Sitzmarker Colon Transit Study — When:_____
- [ ] Small Bowel Follow Thru — When:_____
- [ ] Abdominal Ultrasound — When:_____
- [ ] CT Abdomen/Pelvis — When:_____
- [ ] MRCP — When:_____
- [ ] MRI Abdomen/Pelvis — When:_____

Immunizations

- [ ] None
- [ ] Flu vaccine
- [ ] Hep B
- [ ] Hep B, adult
- [ ] tetanus toxoid
- Other:_____

Previous Surgeries

- [ ] None
- [ ] Appendectomy
- [ ] Bladder suspension
- [ ] C-Section
- [ ] Gallbladder surgery
- [ ] Total colectomy (removal of colon)
- [ ] Removal of part of colon
- [ ] Coronary Artery Bypass Graft (CABG)
- [ ] Defibrillator Placement
- [ ] Exploratory Laparotomy
- [ ] PEG/feeding tube placement
- [ ] Gastric Bypass - type unspecified
- [ ] Hemorrhoidectomy
- [ ] Hiatal Hernia Repair
- [ ] Hysterectomy - Abdominal
- [ ] Hysterectomy - Transvaginal
- [ ] Pacemaker Insertion
- [ ] Small Bowel Resection - Segmental
- [ ] TURP - prostate surgery
- [ ] Aortic valve replacement
- [ ] Mitral valve replacement
- [ ] Whipple Procedure (Pancreatico-duodenectomy)
- [ ] Cardiac stent(s) placement
- Other:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
☐ Civil Union

Alcohol

☐ None

	Type	Quantity	Number	Frequency
☐	Beer			
☐	Wine			
☐	Liquor			

Tobacco

Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker
☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Unknown if ever smoked

	Type	Started	Quit	Quantity	Frequency
☐	Cigarettes				
☐	Smokeless				
☐	Other				

Drug Use

☐ None

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

Family Medical History ☐ No knowledge of family history

Do you have a family history of:

Celiac sprue	Yes ☐ No ☐	Ulcerative Colitis / IBD	Yes ☐ No ☐	Hypertension	Yes ☐ No ☐
Colon polyps	Yes ☐ No ☐	Liver disease	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
Colon cancer	Yes ☐ No ☐				

Health Status	Mother	Father	Brother	Sister	Daughter	Son
Alive	○	○	○	○	○	○
Deceased/At Age	○____	○____	○____	○____	○____	○____
Cause of Death	_____	_____	_____	_____	_____	_____
Diagnoses						
Family history of colon cancer	○	○	○	○	○	○
Family history of celiac disease/sprue	○	○	○	○	○	○
Family history of colon polyps	○	○	○	○	○	○
Family history of inflammatory bowel disease (IBD)	○	○	○	○	○	○
Family history of liver disease	○	○	○	○	○	○

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 Date