

# 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

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.  
X \_\_\_\_\_ Date: \_\_\_\_\_

## MEDICARE AUTHORIZATION

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: \_\_\_\_\_

## 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.**

<p><b>Gastrointestinal</b>  <input type="radio"/> None Y N</p> <p>abdominal pain <input type="radio"/> <input type="radio"/></p> <p>bloating <input type="radio"/> <input type="radio"/></p> <p>change in bowel habits <input type="radio"/> <input type="radio"/></p> <p>constipation <input type="radio"/> <input type="radio"/></p> <p>diarrhea <input type="radio"/> <input type="radio"/></p> <p>gas <input type="radio"/> <input type="radio"/></p> <p>heartburn <input type="radio"/> <input type="radio"/></p> <p>jaundice <input type="radio"/> <input type="radio"/></p> <p>nausea <input type="radio"/> <input type="radio"/></p> <p>rectal bleeding <input type="radio"/> <input type="radio"/></p> <p>stomach cramps <input type="radio"/> <input type="radio"/></p> <p>vomiting <input type="radio"/> <input type="radio"/></p> <p>difficulty swallowing <input type="radio"/> <input type="radio"/></p>	<p><b>Endocrine</b>  <input type="radio"/> None Y N</p> <p>excessive thirst <input type="radio"/> <input type="radio"/></p> <p>hair loss <input type="radio"/> <input type="radio"/></p> <p>heat intolerance <input type="radio"/> <input type="radio"/></p> <p><b>Eyes</b>  <input type="radio"/> None Y N</p> <p>double vision <input type="radio"/> <input type="radio"/></p> <p>loss of vision <input type="radio"/> <input type="radio"/></p> <p>photophobia <input type="radio"/> <input type="radio"/></p> <p><b>Genitourinary</b>  <input type="radio"/> None Y N</p> <p>dark urine <input type="radio"/> <input type="radio"/></p> <p>decrease in urine flow <input type="radio"/> <input type="radio"/></p> <p>dysuria <input type="radio"/> <input type="radio"/></p> <p>frequent urinary infections <input type="radio"/> <input type="radio"/></p> <p>frequent urination <input type="radio"/> <input type="radio"/></p> <p>hematuria <input type="radio"/> <input type="radio"/></p> <p>impotence <input type="radio"/> <input type="radio"/></p> <p>nocturia <input type="radio"/> <input type="radio"/></p> <p>urethral discharge or incontinence <input type="radio"/> <input type="radio"/></p> <p>hesitancy <input type="radio"/> <input type="radio"/></p> <p><b>Hematologic/Lymphatic</b>  <input type="radio"/> None Y N</p> <p>bleeding gums or palpable lymph nodes <input type="radio"/> <input type="radio"/></p> <p>easy bruising <input type="radio"/> <input type="radio"/></p> <p>prolonged bleeding <input type="radio"/> <input type="radio"/></p> <p>adenopathy <input type="radio"/> <input type="radio"/></p> <p><b>Integumentary</b>  <input type="radio"/> None Y N</p> <p>allergies <input type="radio"/> <input type="radio"/></p> <p>dryness <input type="radio"/> <input type="radio"/></p> <p>hives <input type="radio"/> <input type="radio"/></p> <p>itching <input type="radio"/> <input type="radio"/></p> <p>jaundice <input type="radio"/> <input type="radio"/></p> <p>lesions <input type="radio"/> <input type="radio"/></p> <p>rashes <input type="radio"/> <input type="radio"/></p> <p><b>Musculoskeletal</b>  <input type="radio"/> None Y N</p> <p>arthritis <input type="radio"/> <input type="radio"/></p> <p>back pain <input type="radio"/> <input type="radio"/></p> <p>gout <input type="radio"/> <input type="radio"/></p> <p>joint deformity <input type="radio"/> <input type="radio"/></p> <p>joint pain <input type="radio"/> <input type="radio"/></p> <p>muscle weakness <input type="radio"/> <input type="radio"/></p> <p>stiffness <input type="radio"/> <input type="radio"/></p> <p>Raynaud's disease <input type="radio"/> <input type="radio"/></p>	<p><b>Neurological</b>  <input type="radio"/> None Y N</p> <p>dizziness <input type="radio"/> <input type="radio"/></p> <p>fainting <input type="radio"/> <input type="radio"/></p> <p>frequent headaches <input type="radio"/> <input type="radio"/></p> <p>migraine <input type="radio"/> <input type="radio"/></p> <p>numbness or tingling <input type="radio"/> <input type="radio"/></p> <p>seizures <input type="radio"/> <input type="radio"/></p> <p>tremors <input type="radio"/> <input type="radio"/></p> <p>vertigo <input type="radio"/> <input type="radio"/></p> <p>memory loss <input type="radio"/> <input type="radio"/></p> <p><b>Psychiatric</b>  <input type="radio"/> None Y N</p> <p>anxiety <input type="radio"/> <input type="radio"/></p> <p>depression <input type="radio"/> <input type="radio"/></p> <p>difficulty sleeping <input type="radio"/> <input type="radio"/></p> <p>hallucinations <input type="radio"/> <input type="radio"/></p> <p>nervousness <input type="radio"/> <input type="radio"/></p> <p>panic attacks <input type="radio"/> <input type="radio"/></p> <p>paranoia <input type="radio"/> <input type="radio"/></p> <p><b>Respiratory</b>  <input type="radio"/> None Y N</p> <p>asthma <input type="radio"/> <input type="radio"/></p> <p>cough <input type="radio"/> <input type="radio"/></p> <p>dyspnea <input type="radio"/> <input type="radio"/></p> <p>excessive sputum <input type="radio"/> <input type="radio"/></p> <p>coughing up blood <input type="radio"/> <input type="radio"/></p> <p>shortness of breath with exercise <input type="radio"/> <input type="radio"/></p> <p>wheezing <input type="radio"/> <input type="radio"/></p>
<p><b>Allergic/Immunologic</b>  <input type="radio"/> None Y N</p> <p>HIV exposure <input type="radio"/> <input type="radio"/></p> <p>persistent infections <input type="radio"/> <input type="radio"/></p> <p>strong allergic reactions or urticaria <input type="radio"/> <input type="radio"/></p> <p>watery, itchy eyes <input type="radio"/> <input type="radio"/></p> <p>frequent sneezing <input type="radio"/> <input type="radio"/></p> <p>chronic nasal congestion <input type="radio"/> <input type="radio"/></p> <p>chronic rhinorrhea <input type="radio"/> <input type="radio"/></p>	<p><b>Cardiovascular</b>  <input type="radio"/> None Y N</p> <p>chest pain <input type="radio"/> <input type="radio"/></p> <p>dyspnea with exercise <input type="radio"/> <input type="radio"/></p> <p>irregular heart beat <input type="radio"/> <input type="radio"/></p> <p>palpitations <input type="radio"/> <input type="radio"/></p> <p>peripheral edema <input type="radio"/> <input type="radio"/></p>	<p><b>Constitutional</b>  <input type="radio"/> None Y N</p> <p>fatigue <input type="radio"/> <input type="radio"/></p> <p>fever <input type="radio"/> <input type="radio"/></p> <p>loss of appetite <input type="radio"/> <input type="radio"/></p> <p>malaise <input type="radio"/> <input type="radio"/></p> <p>sweats <input type="radio"/> <input type="radio"/></p> <p>weight gain <input type="radio"/> <input type="radio"/></p> <p>weight loss <input type="radio"/> <input type="radio"/></p> <p>rigors <input type="radio"/> <input type="radio"/></p>
<p><b>ENMT</b>  <input type="radio"/> None Y N</p> <p>difficulty swallowing <input type="radio"/> <input type="radio"/></p> <p>dizziness <input type="radio"/> <input type="radio"/></p> <p>ear pain <input type="radio"/> <input type="radio"/></p> <p>nasal obstruction <input type="radio"/> <input type="radio"/></p> <p>nose bleeds <input type="radio"/> <input type="radio"/></p> <p>sore throat <input type="radio"/> <input type="radio"/></p> <p>hearing loss <input type="radio"/> <input type="radio"/></p> <p>tinnitus <input type="radio"/> <input type="radio"/></p> <p>post nasal drip <input type="radio"/> <input type="radio"/></p> <p>hoarseness <input type="radio"/> <input type="radio"/></p> <p>halitosis <input type="radio"/> <input type="radio"/></p>		

**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

- |                            |  |   |  |   |
|----------------------------|--|---|--|---|
| <input type="radio"/> None | <input type="radio"/> Acid Reflux                                | <input type="radio"/> Barrett's Esophagus | <input type="radio"/> celiac disease/sprue | <input type="radio"/> Cirrhosis                 |
|                            | <input type="radio"/> Colon cancer                               | <input type="radio"/> Colon polyp history | <input type="radio"/> Crohn's Disease      | <input type="radio"/> Diverticulosis            |
|                            | <input type="radio"/> abnormal liver tests                       | <input type="radio"/> Fatty Liver         | <input type="radio"/> Gallstones           | <input type="radio"/> Stomach cancer            |
|                            | <input type="radio"/> Slow emptying of the stomach/gastroparesis | <input type="radio"/> helicobacter pylori | <input type="radio"/> Hemorrhoids          | <input type="radio"/> Hepatitis A               |
|                            | <input type="radio"/> Hepatitis B                                | <input type="radio"/> Hepatitis C         | <input type="radio"/> Hiatal hernia        | <input type="radio"/> Irritable Bowel Syndrome  |
|                            | <input type="radio"/> Iron Deficiency Anemia                     | <input type="radio"/> Lactose Intolerance | <input type="radio"/> Pancreatitis         | <input type="radio"/> Primary Biliary Cirrhosis |
|                            | <input type="radio"/> Sjogrens Disease                           | <input type="radio"/> Ulcer Disease       | <input type="radio"/> Ulcerative Colitis   | <input type="radio"/> Diverticulitis            |
- Other: \_\_\_\_\_

### Cardiovascular

- |                            |   |  |  |  |
|----------------------------|---|--|--|--|
| <input type="radio"/> None | <input type="radio"/> Atrial Fibrillation | <input type="radio"/> Carotid artery disease | <input type="radio"/> Coronary Artery Disease  | <input type="radio"/> Deep vein thrombosis |
|                            | <input type="radio"/> Endocarditis        | <input type="radio"/> High blood pressure    | <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Heart Attack         |
|                            | <input type="radio"/> Stroke              | Other: _____                                 |  |  |

### Pulmonary

- |                            |                              |                                 |                                |              |
|----------------------------|------------------------------|---------------------------------|--------------------------------|--------------|
| <input type="radio"/> None | <input type="radio"/> Asthma | <input type="radio"/> Emphysema | <input type="radio"/> C.O.P.D. | Other: _____ |
|----------------------------|------------------------------|---------------------------------|--------------------------------|--------------|

### Other

- |                            |   |  |  |                                |
|----------------------------|---|--|--|--------------------------------|
| <input type="radio"/> None | <input type="radio"/> Arthritis           | <input type="radio"/> Back Pain (chronic ) | <input type="radio"/> Diabetes Mellitus, Insulin Dependent | <input type="radio"/> Glaucoma |
|                            | <input type="radio"/> Renal insufficiency | <input type="radio"/> Dementia             | <input type="radio"/> HIV                                  | <input type="radio"/> Seizures |
|                            | <input type="radio"/> Sickle Cell Trait   | Other: _____                               |  |                                |

## Diagnostic Studies/Tests

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### GI Endoscopy

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- |                            |  |   |   |   |
|----------------------------|--|---|---|---|
| <input type="radio"/> None | <input type="radio"/> EGD<br>When: _____               | <input type="radio"/> Bravo pH study<br>When: _____     | <input type="radio"/> Colonoscopy<br>When: _____                          | <input type="radio"/> ERCP<br>When: _____ |
|                            | <input type="radio"/> Capsule Endoscopy<br>When: _____ | <input type="radio"/> PEG tube placement<br>When: _____ | <input type="radio"/> Double balloon small bowel endoscopy<br>When: _____ | <input type="radio"/> EUS<br>When: _____  |
|                            | <input type="radio"/> Liver Biopsy<br>When: _____      | <input type="radio"/> Other: _____                      |   |   |
- 

### Radiology tests

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- |   |  |   |  |
|---|--|---|--|
| <input type="radio"/> Gastric Emptying Study<br>When: _____ | <input type="radio"/> HIDA / CCK Scan<br>When: _____   | <input type="radio"/> Sitzmarker Colon Transit Study<br>When: _____ | <input type="radio"/> Small Bowel Follow Thru<br>When: _____ |
| <input type="radio"/> Abdominal Ultrasound<br>When: _____   | <input type="radio"/> CT Abdomen/Pelvis<br>When: _____ | <input type="radio"/> MRCP<br>When: _____                           | <input type="radio"/> MRI Abdomen/Pelvis<br>When: _____      |
- 

### Immunizations

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- |                                   |                             |                                    |                                      |                                    |
|-----------------------------------|-----------------------------|------------------------------------|--------------------------------------|------------------------------------|
| <input type="radio"/> None        |                             |                                    |                                      |                                    |
| <input type="radio"/> Flu vaccine | <input type="radio"/> Hep B | <input type="radio"/> Hep B, adult | <input type="radio"/> tetanus toxoid | <input type="radio"/> Other: _____ |
- 

### Previous Surgeries

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



**Consent to Share Data**

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I consent to having my medical and demographic information shared with other health care entities.

Yes       No

**Reminder Preference**

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I would like to receive preventive care and follow up care reminders.

Yes       No

**Patient Signature**

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**Date:**

**Reviewed with**

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Patient       Parent       Guardian       Not Present

Staff Signature

Date