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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____
MRN: _____ Date Of Birth: _____
Age: _____ Notes: _____

Email

Please check one as your preferred email for communications

Personal: _____ Work: _____

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 Patient declines to specify Other: _____

Contact Preference

Telephone call Patient declines to specify Other: _____

Allergies

Patient has no known allergies Patient has no known drug allergies
 Latex Shellfish Seafood Penicillins Other: _____
Antibiotics Cipro Erythromycin Flagyl Sulfa (Sulfonamide Antibiotics)
Other Medications Codeine Sulfate Demerol Tylenol fentanyl citrate-0.9%NaCl (PF)
 propofol (PF) morphine (PF) Aspirin Iv Dye, Iodine Containing Contrast Media

Current Medications

None

Name	Dose	How taken?

Past or Present Medical Conditions

None

- | | | | | |
|--|--|--|---|--|
| <input type="radio"/> Anemia | <input type="radio"/> Asthma | <input type="radio"/> Atrial Fibrillation | <input type="radio"/> Back Pain (chronic) | <input type="radio"/> Barrett's Esophagus |
| <input type="radio"/> Breast cancer | <input type="radio"/> Chronic Lung Disease | <input type="radio"/> Cirrhosis | <input type="radio"/> Colitis | <input type="radio"/> Colon cancer |
| <input type="radio"/> Colon polyps | <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Crohn's Disease | <input type="radio"/> Depression | <input type="radio"/> Diabetes Mellitus |
| <input type="radio"/> Diverticulitis | <input type="radio"/> Diverticulosis | <input type="radio"/> Duodenal Ulcer | <input type="radio"/> Emphysema | <input type="radio"/> Fatty Liver |
| <input type="radio"/> Urinary tract infection (frequent) | <input type="radio"/> Gall stones | <input type="radio"/> Glaucoma | <input type="radio"/> Gout | <input type="radio"/> Heart Attack |
| <input type="radio"/> Heart Murmurs | <input type="radio"/> Hepatitis | <input type="radio"/> Hepatitis B | <input type="radio"/> Hepatitis C | <input type="radio"/> Hiatal hernia |
| <input type="radio"/> High blood pressure | <input type="radio"/> Elevated Cholesterol | <input type="radio"/> History of suicide attempt | <input type="radio"/> HIV / AIDS | <input type="radio"/> Hyperthyroidism |
| <input type="radio"/> Hypothyroidism | <input type="radio"/> Irritable Bowel Syndrome | <input type="radio"/> Kidney Disease | <input type="radio"/> Kidney Failure | <input type="radio"/> Kidney Stones |
| <input type="radio"/> Lactose intolerance | <input type="radio"/> Lupus | <input type="radio"/> Migraines | <input type="radio"/> Osteoarthritis | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Pancreatitis | <input type="radio"/> Parkinsons | <input type="radio"/> Pneumonia | <input type="radio"/> Acid Reflux | <input type="radio"/> Rheumatoid arthritis |
| <input type="radio"/> Seizures | <input type="radio"/> Sexually Transmitted Disease | <input type="radio"/> Skin Cancer | <input type="radio"/> Sleep apnea | <input type="radio"/> Stomach Ulcer |
| <input type="radio"/> Stroke | <input type="radio"/> TB exposure | <input type="radio"/> Ulcerative Colitis | | |

Previous Procedures

None

- | | | | | |
|--|--|--|--|--|
| <input type="radio"/> Appendectomy
When: _____ | <input type="radio"/> Bilateral tubal ligation
When: _____ | <input type="radio"/> Breast
When: _____ | <input type="radio"/> C-Section
When: _____ | <input type="radio"/> CATH - Cardiac
When: _____ |
| <input type="radio"/> Colon Resection
When: _____ | <input type="radio"/> Colonoscopy
When: _____ | <input type="radio"/> EGD / Upper endoscopy
When: _____ | <input type="radio"/> ERCP
When: _____ | <input type="radio"/> Heart Bypass
When: _____ |
| <input type="radio"/> Gallbladder Removed
When: _____ | <input type="radio"/> Hernia Repair - Hiatal - Umbilical - Inguinal
When: _____ | <input type="radio"/> Hemorrhoids
When: _____ | <input type="radio"/> Joint replacement
When: _____ | <input type="radio"/> Kidney
When: _____ |
| <input type="radio"/> Liver biopsy
When: _____ | <input type="radio"/> Obesity surgery
When: _____ | <input type="radio"/> Ovary surgery
When: _____ | <input type="radio"/> Prostate
When: _____ | <input type="radio"/> Stomach
When: _____ |
| <input type="radio"/> Thyroidectomy
When: _____ | <input type="radio"/> Tonsillectomy
When: _____ | <input type="radio"/> Tubal Ligation
When: _____ | <input type="radio"/> Uterus
When: _____ | <input type="radio"/> Hepatitis C screening
When: _____ |

Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

Review Of Systems

Allergic/Immunologic

None Y N
 persistent infections
 strong allergic reactions or urticaria

Cardiovascular

None Y N
 chest pain
 irregular heart beat
 ankle swelling
 heart murmur

Constitutional

None Y N
 fatigue
 fever
 loss of appetite
 chills
 sweats
 weight gain
 weight loss

ENMT

None Y N
 nose bleeds
 sore throat
 blurred vision
 hoarseness

Gastrointestinal

None Y N
 abdominal pain
 anal/rectal pain
 abdominal swelling or bloating
 change in bowel habits
 constipation
 diarrhea
 gas
 heartburn
 jaundice
 nausea
 rectal bleeding
 stomach cramps
 vomiting
 blood in stool
 difficulty swallowing
 black stool
 hemorrhoids
 incontinence
 rectal urgency

Endocrine

None Y N
 hair loss
 heat intolerance

Genitourinary

None Y N
 dark urine
 frequent urination
 blood in urine
 painful urination

Hematologic/Lymphatic

None Y N
 bleeding gums or palpable lymph nodes
 easy bruising
 prolonged bleeding
 swollen glands

Musculoskeletal

None Y N
 back pain
 joint pain
 muscle weakness
 stiffness

Neurological

None Y N
 dizziness
 frequent headaches
 tremors
 memory disturbance

Psychiatric

None Y N
 anxiety
 depression
 difficulty sleeping
 nervousness
 panic attacks

Respiratory

None Y N
 cough
 shortness of breath
 wheezing
 coughing up blood

Pharmacy

Name _____ Address _____ Phone _____

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature

Date

Wilmington Gastroenterology Associates

Demographics

Patient Name _____ Date of Birth ____/____/____
(First) (Middle) (Last)

Address _____ City _____ State _____ Zip _____

Home Ph: _____ - _____ - _____ Cell Ph: _____ - _____ - _____ Work Ph: _____ - _____ - _____

Social Security _____ - _____ - _____ Sex: **M** **F** Email address _____
(circle)

Emergency Contact _____ Ph: _____ - _____ - _____ 2nd Ph: _____ - _____ - _____

Primary Doctor _____ Primary Doctor Phone _____ - _____ - _____

Preferred Pharmacy/Location _____

How did you find out about us? A) another doctor referred you B) yellow pages
(circle) C) a friend or family member D) other _____

HIPAA Privacy Practices Acknowledgment 2013

I have received a copy of Wilmington Gastroenterology Associates HIPAA Notice of Privacy Practices that explains how my Protected Health Information (PHI) may be used. Additional copies of the Notice of Privacy Practices are available at the front desk. Questions about our Notice of Privacy Practices may be directed to:
Attn: Privacy Officer Wilmington Gastroenterology, 5115 Oleander Drive, Wilmington, NC 28403

I acknowledge receipt of Wilmington Gastroenterology's new notice of privacy practices effective September of 2013. In addition, my medical information may be shared with the individuals listed below. (Please exclude any doctors)

Please check this box if it is OK to leave a message on your answering machine that contains PHI

Name and relationship Phone Name and relationship Phone

Name and relationship Phone Name and relationship Phone

Please check this box if you do not want us to disclose your PHI to anyone

Consent for Treatment: I hereby authorize the performance of medical treatment that may be advised or recommended by Wilmington Gastroenterology Associates, including necessary and/or beneficial services and use of equipment in the performance of the treatment.

Financial Agreement: I understand the Wilmington Gastroenterology files insurance as a courtesy and that I am ultimately responsible for payment for the services provided. I authorize Wilmington Gastroenterology to furnish any necessary information to insurance carriers concerning my illness/treatment and request payment be made directly to Wilmington Gastroenterology. Patients that do not give adequate cancellation notice for appointments will incur a \$25 no show fee. Any patient credit balances under \$5.00 will not be refunded unless a written request is received.

X _____
Patient / Guardian signature

Date