GASTROENTEROLOGY CENTER OF NORTHERN VIRGINIA, LTD.

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____

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 ○ Prohibited by state law

Ethnicity

○ Hispanic or Latino ○ Not Hispanic or Latino ○ Patient declines to specify ○ Prohibited by state law

Sex

○ Male ○ Female ○ Other

Preferred Language

○ English ○ Patient declines to specify

Contact Preference

○ Letter ○ Email ○ Patient declines to specify Other:_____

Pharmacy

Name Address Phone

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies
- ◯ Adhesive Tape
- ◯ Codeine Sulfate
- ◯ Erythromycin
- ◯ Penicillins
- ◯ Shellfish
- ◯ Iv Dye, Iodine Containing
- ◯ Latex gloves
- Other: _____
- Other: _____

Current Medications

◯ None

Name	Dose	How taken?

Immunizations

◯ None

- ◯ Flu vaccine When: _____
- ◯ Hep A When: _____
- ◯ Hep B When: _____
- ◯ Pneumovax When: _____
- ◯ TB skin test When: _____

Diagnostic Studies/Tests

◯ None

- ◯ Colonoscopy When: _____
- ◯ EGD When: _____
- ◯ CT Abdomen/Pelvis When: _____
- ◯ MRI Abdomen/Pelvis When: _____
- ◯ ERCP When: _____

Previous Procedures

◯ None

- ◯ Gallbladder removed
- ◯ Appendectomy
- ◯ Colon resection
- ◯ Small Bowel Resection
- ◯ Exploratory Laparoscopy
- ◯ Gastric Bypass
- ◯ Gastric Lap Band
- ◯ Hemorrhoidectomy
- ◯ Hemorrhoid banding
- ◯ Abdominoplasty
- ◯ Hysterectomy - Abdominal
- ◯ Bilateral Tubal Ligation (BTL)
- ◯ Mastectomy R Breast
- ◯ Pacemaker Insertion
- ◯ Defibrillator Placement
- ◯ Coronary Artery Bypass Graft (CABG)
- ◯ Abdominal aortic aneurysm (AAA) repair
- ◯ Heart valve replacement
- ◯ Cardiac Cath - with stent placement
- ◯ Joint Replacement
- ◯ Back Surgery
- ◯ Fibromyalgia
- Other: _____
- Other: _____

Past or Present Medical Conditions

☐ None

Gastroenterology/Hepatology

☐ Colon polyp history ☐ Colon cancer ☐ Irritable Bowel Syndrome ☐ Diverticulitis
☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Gastroesophageal Reflux Disease (GERD) ☐ Barrett's Esophagus
☐ Ulcer Disease ☐ Hepatitis B ☐ Hepatitis C ☐ Fatty Liver
☐ Cirrhosis ☐ Celiac Disease ☐ Bowel Obstruction ☐ Pancreatitis
☐ Anemia Other: _____ Other: _____

Cardiology

☐ Coronary Artery Disease ☐ Congestive Heart Failure ☐ Heart Attack ☐ High blood pressure
☐ Atrial Fibrillation ☐ Vascular Disease ☐ High Cholesterol ☐ Stroke
☐ Transient Ischemic Attack ☐ Valvular heart disease ☐ Pacemaker ☐ Coronary Artery Stents
Other: _____ Other: _____

Pulmonology

☐ C.O.P.D. ☐ Asthma ☐ Sleep apnea ☐ Blood Clots (leg)
☐ Blood Clots (lung) ☐ Wheezing Other: _____ Other: _____

Other

☐ Anxiety disorder ☐ Arthritis ☐ Bipolar disorder ☐ Body piercings
☐ Breast cancer ☐ Current pregnancy ☐ Depression ☐ Diabetes Mellitus, Insulin Dependent (Type 1)
☐ Diabetes Mellitus, Non-Insulin Dependent (Type 2) ☐ Fibrositis / Fibromyalgia ☐ Gout ☐ HIV exposure
☐ HIV infection ☐ Hypothyroidism ☐ Kidney disease ☐ Kidney stones
☐ Lung cancer ☐ Ovarian Cancer ☐ Prostate Cancer ☐ Skin Cancer
☐ Seizures ☐ Tattoos

Social History

Occupation: _____ Number of Children: _____

Marital Status

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

Alcohol

☐ None

Type
☐ Occasionally
☐ Daily

Quantity
_____
_____

Caffeine

☐ None
☐ Occasionally ☐ Daily

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				
○ Cigar				
○ Chewing Tobacco				

Drug Use

○ None

Type	Quantity	Number	Frequency
○ IV or intranasal drugs			Times / month
○ Recreational			Times / month

Exercise

○ None

○ Regular exercise ○ Occasional exercise

Family Medical History

○ No knowledge of family history

No family history of

○ Celiac sprue
○ Colon polyps
○ Liver disease
○ Ulcerative Colitis / IBD
○ Colon cancer
○ Crohn's disease
○ Stomach cancer

Health Status	Mother	Father	Sister	Brother	Grandmother	Grandfather
Age/Date of Birth						
Healthy	○	○	○	○	○	○
Ill	○	○	○	○	○	○
Seriously Ill	○	○	○	○	○	○
Disabled	○	○	○	○	○	○
In Remission	○	○	○	○	○	○
Alive	○	○	○	○	○	○
Deceased/At Age	○	○	○	○	○	○
Cause of Death						
Diagnoses						
Celiac Disease	○	○	○	○	○	○
Colon cancer	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○
Crohn's disease	○	○	○	○	○	○
Gallbladder disease	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○
Ulcerative colitis	○	○	○	○	○	○
Other:	○	○	○	○	○	○

Review Of Systems

Allergic/Immunologic

None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

None	Y	N
chest pain	○	○
dyspnea with exercise	○	○
irregular heart beat	○	○
orthopnea	○	○
palpitations	○	○
peripheral edema	○	○
syncope	○	○

Constitutional

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

ENMT

None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○

Endocrine

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

Eyes

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

Gastrointestinal

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

Genitourinary

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

Hematologic/Lymphatic

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

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	○	○

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	○	○

Consent to Import Medication History

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

○ Yes ○ No

Reminder Preference

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

○ Yes ○ No

Reviewed with

○ Patient ○ Parent ○ Guardian ○ Not Present

Signature

Signature Date

Gastroenterology Center of Northern Virginia

Permission Signature Document

I, _____ hereby give my consent to Gastroenterology Center of Northern Virginia *to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of*

_____.

I acknowledge the review and/or receipt of the physician's Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential information. I understand that GC0FN0VA has reserved the right to change its privacy practices, and that a copy of any revised Notice will be available to me upon written request.

I also authorize the physicians and staff of Gastroenterology Center of Northern Virginia to:

1. I **do not** want messages left for me. *(please check here)* _____
2. Leave a detailed message with the type of test(s) performed. test results and/or any other comments related to my health at:

_____ Cell phone_____ Home Phone_____ Work Phone

HIPAA INFORMATION RELEASE

1. Release any and all information pertaining to my health care, test results, procedures, billing, and/or accounting information to the following person(s)or agencies:

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

I,_____ understand that this consent will be actively enforced and any changes to this HIPAA release must be done in writing.

Patient's Name:_____

Signature:_____Date:_____

GASTROENTEROLOGY CENTER OF NORTHERN VIRGINIA

OFFICE POLICIES

INSURANCE REFERRALS: Please have necessary referral forms with you at the time of your appointment If required by your insurance. This applies to HMO and managed care plans. Please arrange this in advance with your primary care doctor.

INSURANCE CO-PAYS: Please be prepared to pay your copay at the time of service. If you are unsure of the amount due, please obtain that information prior to your appointment. We accept exact cash, checks, or credit cards. Visa, MasterCard, and Discover are accepted at our offices.

TARDINESS: We make every attempt to see you as close to your appointment time as possible. The doctors do however sometimes run late due to the nature of specialty practice. Please call If you are running late. If you arrive more than 15 minutes late for your appointment, we will see you If possible. It may be necessary to reschedule your appointment. Please come prepared for your appointment with all records and paperwork.

MISSED APPOINTMENTS: There will be a $30.00 charge for office appointments missed or canceled with less than 24 hours' notice. Advance notice of cancellation allows our office to offer the appointment to another patient. Your understanding is very much appreciated.

PROCEDURE APPOINTMENTS: There is a $150.00 charge for canceling with less than 5 business days advance notice, so that the appointment may be offered to another patient. This charge Is the responsibility of the patient and must be paid before rescheduling your procedure.

MEDICAL RECORD/FORMS: There Is a fee for copying or faxing your complete medical record. Please keep any copies of any records you give us for your personal file. We do not provide copies of other doctor's records to you. Each healthcare provider Is responsible to provide those records to you directly. There Is a $30.00 fee for completing forms, disability applications, dictated letters requested, etc.

PRESCRIPTIONS: Written prescriptions will be provided at your office appointment. If you require a 90-day supply for mail order, please ask the doctor at the time of your appointment. Insurance authorization (if required) for medications, can take up to a week. To expedite the process, be sure that you have provided current Insurance and prescription card Information. We sometimes need to change medications to coincide with your plan's preferred medications. Please allow at least 5 days to process local refills or mail order. Please keep office updated on your current pharmacy.

I have read and understand the office policies of Gastroenterology Center of Northern Virginia.

Patient's Name: _____

SIGNATURE: _____ DATE: _____

Gastroenterology Center of Northern Virginia

Patient Name: _____ Birthdate: _____

Who is your Primary Care Physician? _____

What health insurance company is your coverage with? _____

Do you have an Advanced Directive? **Yes or No**

An Advance Directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.

Have you had a pneumococcal (pneumonia) vaccine? **Yes or No**

Signature: _____ Date: _____