PATIENT MEDICAL HISTORY

MRN: _____ Primary Care Physician: _____
Date: _____ Name: _____ Date of Birth: _____ Age: __
Address: _____ Daytime Phone: _____
Insurance: _____Subscriber if Different: _____
Employer: _____
Reason for Visit: _____

Who referred you to this office?
Name: _____ Phone: _____
Address: _____
Please List all your Medications and the dosages, including over-the-counter medications which you take regularly and vitamins

☐ None

Name	Dose	How is it taken?

☐ See Attached List.

Are you allergic to or had severe reactions to any medications: ☐ Yes ☐ No
If yes, which medications(s) and what type of reaction? _____
Do you take Aspirin: ☐ Yes ☐ No. If yes, which one(s) _____
Do you take Plavix: ☐ Yes ☐ No. if yes, which one(s) _____
Do you take any diet medications: ☐ Yes ☐ No. If yes, which one(s) _____
Latex Sensitive ☐ Yes ☐ No

List any surgeries you have had, what type and when, in order of the most recent.

☐ None

Date:	Surgery:

Date of Last Colonoscopy _____

Family History of Cancer ☐ Yes ☐ No Type: _____ Relationship: _____

Family History of Colon Cancer ☐ Yes ☐ No Relationship: _____

Family History of Colon Polyps ☐ Yes ☐ No Relationship: _____

Women Only: (if N/A leave blank)

First Day of Most recent menstrual period: _____

Number of Pregnancies: _____ Number of Live Birth: _____

Are you Pregnant? ☐ Yes ☐ No

Do you smoke, or have you ever smoked, ☐ Yes ☐ No. If yes, packs per day____ how many years ____

If you've quit smoking, when did you quit? _____

Do you use alcohol ☐ Yes ☐ No. If yes, Drinks/Day_____ Week _____ Month _____

	Yes	No		Yes	No
EXTREMITIES:					
ARTHRITIS			RHEUMATOLOGIC DISEASE		
CNS:					
SEIZURE			CONVULSION		
EENT:					
GLAUCOMA					
PULMONARY:					
ASTHMA			PULMONARY EMBOLUS		
EMPHESEMIC					
CV:					
HYPERTENSION			HEART ATTACK		
CORONARY STENT			HEART MURMUR		
ENDOCRINE:					
DIABETES			THYROID DISEASE		
GI:					
ULCER			HEPATITIS		
LIVER DISEASE			GASTROINTESTINAL REFLUX		
GU:					
URINARY LEAKAGE			URINARY TRACT INFECTION		
KIDNEY DISEASE			PROSTATE DISEASE		
HEMOTOLOGIC:					
TRANSFUSION			BLEEDING PROBLEM		
ANEMIA			AIDS/HIV		
CANCER:					
HX OF CANCER			HX OF RADIATION		
HX OF CHEMOTHERAPY					
PSYCH:					
HX OF DEPRESSION			ANXIETY		
OTHER					
INFECTION:					
HX OF TB					

Department of Surgery
Division of Colon & Rectal Surgery

HIPAA/CONSENT FORM

Dear Patient:

Please carefully read this consent form and then sign.

Depending on the problem which you have, your surgeon will take a history and perform a physical examination to determine the causes of your complaint and advise you on the possible remedies.

The physical examination may include an examination of the external portion of the anus, internal portion of the anus with anoscope and, if appropriate, a procto-sigmoidscope. A proctosigmoidoscopy is generally performed to determine the source of the bleeding and carries an approximate risk of 1 in 1,000 risk of perforation of the colon. An abnormality found at the time of the proctosigmoidoscopy may be biopsied in the office. This carries an additional risk of bleeding and perforation. Other procedures which may be performed in the office include the removal thrombosed hemorrhoids, drainage of a rectal abscess and treatment of perianal lesion. These surgical procedures carry a small risk of postoperative bleeding, infection and reaction to the local anesthesia.

Before any therapeutic procedure is performed the doctor will thoroughly discuss with you, your options and obtain your verbal consent prior to performing the procedure.

If you have any questions about this consent form or the procedure outline, please feel free to discuss them with your doctor at the time of your consultation.

I have read the above and consent to examination and treatment by Dr. _____

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

_____ _____

Physician Signature Date

Name: _____

MRN: _____

DOB: _____

(Label)

POA OTHER LEGAL DOCUMENT

Authorization For the Use & Disclosure of Protected Health Information

In accordance with HIPAA privacy laws, GW Medical Faculty Associates ("MFA") may not use or disclose your protected health information ("PHI") without your written authorization, except as provided in our Notice of Privacy Practices. In order for MFA physicians, employees, or representatives to share your PHI with family members, friends, and/or people you choose to have knowledge of your care, you must complete this form.

** You must specifically state your spouse's name to give us authorization to communicate your PHI to them.

I, _____ (print name) hereby authorize MFA physicians, employees, and/or representatives to share the following PHI with the person(s) listed below.

PLEASE CHECK ALL THAT APPLY

- ☐ Test results (e.g. lab results, x-rays, biopsies, CT scans, MRIs);
- ☐ Treatment information (e.g. discussions about prognosis, planned or current procedures, care options);
- ☐ Information pertaining to outside appointment made by our office, (e.g. the date and time of appointment, facility where testing or procedure will be done, why the appointment is being made);
- ☐ Billing issues (e.g. balance due, insurance issues)
- ☐ Other _____

☐ DO NOT RELEASE MY PROTECTED MEDICAL INFORMATION TO ANYONE

My Protect health information may be shared with the following individual(s):

_____	_____	_____
(Name)	(Relationship)	(Phone #/Email)
_____	_____	_____
(Name)	(Relationship)	(Phone #/Email)

With my signature I affirm I am greater than 18 years of age and capable of giving consent. I acknowledge and understand that this authorization will be maintained in my medical record and will remain in effect until revoked by me in writing. I understand what it is my responsibility to notify a representative of MFA if any of the above information changes.

_____	_____
Patient Signature	Date
_____	_____
Witness Signature	Date

You may provide a designated telephone number where messages containing PHI may be left.

☐ Lab results and medical advice may be left by voicemail at the following number:_____

DEMOGRAPHICS

The GW Medical Faculty Associates
Department of Surgery

Meaningful Use Form

Patient Information:

Last Name: _____ First Name: _____

DOB: _____

We are now required to collect preferred language, race, and ethnicity. If you do not report this information you may choose to decline. Thank You for your cooperation.

Preferred Language	**Race**	**Ethnicity**
☐ English ☐ Spanish ☐ Other: _____ ☐ Decline to Report	☐ Asian ☐ Black or African American ☐ American Indian/Alaskan Indian ☐ Pacific Islander/Native Hawaiian ☐ Caucasian ☐ Hispanic/Latino ☐ Other ☐ Unknown ☐ Decline to Report	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Report

In the near future, we will have a patient web portal available for you to communicate with our office and access your health information. We would like to collect your email address in preparation of launching this product.

My email Address is: _____@ _____.com

In an effort to better serve you, we would like to update your preferred pharmacy information. This information will be used to electronically prescribe your medications:

Pharmacy Name: _____

Address: _____

Phone Number: _____