Guy R. Winzenried MD FACG

PATIENT NAME: First ________________ **M:** ____________ **Last** ________________

DATE OF BIRTH: ____________________ **GENDER:** (CIRCLE ONE) **Male** **Female**

ADDRESS: ____ **UNIT** __________

CITY/STATE/ZIP ____

HOME PHONE # ____________________ **CELL #** ____________________

Please circle Primary # you prefer to be contacted at Home or Cell

EMAIL ____

RACE (CIRCLE ONE) **WHITE** **AFRICAN AMERICAN** **ASIAN** **AMERICAN INDIAN** **UNKN**

ETHNICITY (CIRCLE ONE) **HISPANIC/LATINO / NOT HISPANIC/LATINO / PATIENT DECLINES TO SPECIFY / PROHIBITED BY LAW**

SOCIAL SECURITY # ____

LOCAL PRIMARY PHYSICIAN ____________________ **REFERRING PHY** ____________________

MARITAL STATUS (circle one): **Single** **Married** **Divorced** **Widowed**

EMERGENCY CONTACT NAME: ____

RELATIONSHIP TO PATIENT: ____________________ **Phone** ____________________
(circle one) Home Cell Work

PHARMACY ____________________ **PHONE#** ____________________

DRUG ALLERGIES ____

NORTHERN ADDRESS INFORMATION

STREET ADDRESS ____________________ UNIT ________ CITY/STATE/ZIP ____________________

PHONE # (include Area Code): ____

By signing below, I acknowledge the following:
I hereby authorize the provider to treat me.
I hereby attest that the personal and financial information given above is true and that my personal identification or insurance information has not been falsified.
A parent or guardian responsible for payment of the bill is accompanying the child at the time of service unless a separate permission form has been signed. Guy R. Winzenried MD cannot be bound by any divorce or other family relationship contracts.
I hereby authorize insurance benefits including Medicare benefits, to be paid directly to the physician providing services and recognize it is my responsibility to pay for all non-covered services. I also, authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid (CMS) and it's agents or any other third party liability or insurance carrier, any information needed to determine these benefits or the benefits payable for related services.
I have reviewed and understand all of the second page of this document, including the HIPAA.
Notice of Privacy Practice Statement, as indicated with my signature and date below.

SIGNATURE: ____ DATE: ____________________

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Diplomate American Board of Internal Medicine, Gastroenterology and Hepatology

Patient Interview Form

Patient Information

First Name: ____________ Last Name: ____________

Date Of Birth: ____________ Age: ____________

Sex

- ◯ Male
- ◯ Female
- ◯ Other

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies
- ◯ Codeine Sulfate
- ◯ Penicillins
- ◯ Anesthesia
- ◯ Sulfa (Sulfonamide Antibiotics)
- ◯ aspirin (bulk)

Other: ____________

Current Medications

- ◯ None

Name	Dose

Social History

Occupation: ____________ Number of Children: ____________

Marital Status

- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Separated
- ◯ Widowed

Alcohol

- ◯ None

Type	Quantity	Number	Frequency

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

Drug Use

- None
- Narcotics

Exercise

- None
- I walk
- I jog
- I Bike
- I Golf
- Tennis
- Lift Weights
- Swim
- Yoga

Past or Present Medical Conditions

- None
- Anemia
- Cirrhosis
- Colitis
- Colon cancer
- Colon polyps
- Crohn's Disease
- Pancreatitis
- Diabetes Mellitus
- Diverticulitis
- Diverticulosis
- Duodenal Ulcer
- Fatty Liver
- Gallstones
- Hepatitis
- Hepatitis B
- Hepatitis C
- Hiatal hernia
- IBS
- Lactose Intolerance
- Glaucoma
- Stomach Ulcer
- Ulcerative Colitis
- Asthma
- Atrial Fibrillation
- Back Pain (chronic)
- Breast cancer
- Skin Cancer
- Congestive Heart Failure
- Depression
- Stroke
- Heart Attack
- Heart Murmurs
- High blood pressure
- High Cholesterol
- High Triglycerides
- Irregular Heart Beat
- Chronic Kidney Disease
- TB exposure
- Migraines
- Osteoarthritis
- Seizures
- Sleep apnea
- Thyroid disorder
- Uterine Cancer
- Prostate Cancer
- HIV
- Ischemic heart disease
- Other ____________
- C.O.P.D.
- Coronary artery disease

Previous Procedures

- None
- Colonoscopy
- EGD
- C-Section
- Cardiac Surgery
- Joint Surgery
- Gallbladder removed
- Thyroidectomy
- Tonsillectomy
- Pacemaker
- Nephrectomy
- Gastric By-Pass
- Gastric Band
- Breast Augmentation
- Liver Biopsy
- Hemorrhoidectomy
- Coronary artery bypass surgery
- Hysterectomy
- Prostatectomy
- Appendectomy

Immunizations

- None
- Hep A, adult
- Hep B, adult
- Influenza, seasonal, injectable
- Pneumonia

Family Medical History

◯ No knowledge of family history

No family history of ◯ Colon cancer ◯ Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather
Colon Cancer - Age diagnosed____	◯	◯	◯	◯	◯	◯	◯	◯
Colon Polyps	◯	◯	◯	◯	◯	◯	◯	◯
Ulcerative colitis, unspecified	◯	◯	◯	◯	◯	◯	◯	◯
Crohn's Disease	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Diabetes	◯	◯	◯	◯	◯	◯	◯	◯
Impaired gallbladder function	◯	◯	◯	◯	◯	◯	◯	◯
Family History of Heart Trouble	◯	◯	◯	◯	◯	◯	◯	◯
Liver Cancer/Disease	◯	◯	◯	◯	◯	◯	◯	◯
Ulcer Disease	◯	◯	◯	◯	◯	◯	◯	◯
Irritable bowel syndrome	◯	◯	◯	◯	◯	◯	◯	◯
prostate cancer	◯	◯	◯	◯	◯	◯	◯	◯
breast cancer	◯	◯	◯	◯	◯	◯	◯	◯
Pancreas Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Lung Cancer	◯	◯	◯	◯	◯	◯	◯	◯
Cervical/Ovarian Cancer	◯	◯	◯	◯	◯	◯	◯	◯

MARK YES ONLY

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		

Genitourinary
None

	Y	N
dark urine		
decrease in urine flow		
dysuria		
frequent urinary infections		
frequent urination		
hematuria		
impotence		
nocturia		
urethral discharge or incontinence		

Gastrointestinal
None

	Y	N
abdominal swelling		
change in bowel habits		
constipation		
diarrhea		
gas		
heartburn		
jaundice		
nausea		
rectal bleeding		
stomach cramps		
vomiting		
difficulty swallowing		
dyspepsia		
abdominal pain upper		
abdominal pain lower		
anal/rectal pain		
belching		
black stools		
bloating		
dairy intolerance		
hemorrhoids		
mucus in stool		
pain with bowel movement		
rectal urgency		
reflux		
soiling stool/incontinence		
weight loss less than 10 lbs		
weight loss more than 10 lbs		
weight gain more than 10 lbs		
weight gain less than 10 lbs		

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