Gastroenterology Specialists
of Southwest Florida
DIPLOMATE,AMERICAN BOARD OF GASTROENTEROLOGY

1656 Medical Blvd Suit 301. Naples, FL 34110
Phone: (239) 593-6201 Fax: (239)593-6202
www.gastronaples.com

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Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

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

◯ Other Race ◯ 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 ◯ Unknown

Sex

◯ Male ◯ Female ◯ Other ◯ Unknown

Contact Preference

◯ email ◯ Phone Call ◯ All of the above ◯ Patient declines to specify

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies

◯ Codeine ◯ Penicillins ◯ Anesthesia ◯ Sulfa ◯ aspirin

Other:_____

Current Medications

○ None

Name Dose

Immunizations

○ None

○ Hep A, adult When:_____ ○ Hep B, adult When:_____ ○ FLU SHOT 2021-2022 When:_____ ○ Pneumonia When:_____ ○ FLU SHOT 2022-2023 When:_____

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/COPD ○ Back Pain (chronic) ○ Breast cancer

○ Skin Cancer ○ Congestive Heart Failure ○ Depression ○ Stroke/Tia ○ 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 _____ ○ Coronary Artery Disease ○ kidney stones ○ Currently Pregnant

○ Fraility ○ Wheelchair Bound ○ O2 Dependency ○ Dementia ○ Parkinson's Disease

○ Alzheimer's Disease ○ History of Falls ○ Heart Disease ○ Atrial Fibrillation

Previous Procedures

○ None

○ Colonoscopy ○ EGD ○ C-Section ○ Cardiac Stents ○ Joint Surgery

○ Gallbladder removed ○ Thyroidectomy ○ Tonsillectomy ○ Pacemaker ○ Nephrectomy

○ Gastric By-Pass ○ Gastric Band ○ Breast Augmenation ○ Hemorrhoidectomy ○ Coronary artery bypass surgery

○ Hysterectomy ○ Prostatectomy ○ Appendectomy ○ Adenoidectomy ○ Cardiac Cath.

○ Defibrillator/AICD

Social History

Occupation:_____ Number of Children:_____

Marital Status

○ Single ○ Married ○ Divorced ○ Widowed

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

Alcohol

- None

Type	Quantity	Number	Frequency

Exercise

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

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 Disease/Cancer	○	○	○	○	○	○	○	○
Ulcer Disease	○	○	○	○	○	○	○	○
prostate cancer	○	○	○	○	○	○	○	○
breast cancer	○	○	○	○	○	○	○	○
Pancreas Cancer	○	○	○	○	○	○	○	○
Cervical/Uterine Cancer	○	○	○	○	○	○	○	○
Lung Cancer	○	○	○	○	○	○	○	○
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	◯	◯

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

Pharmacy

Name Address Phone

Consent to Share Data

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

◯ Yes ◯ No

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Patient Demographics:

Name:_____
Last First Middle Initial

DOB:_____ **Sex: M ○ F ○** **Martial Status: M ○ S ○ W ○ D ○**

Current Address:_____
City State Zip

Northern Address (If Any):_____

Home Phone:_____ **Cell Phone:** _____

Northern Phone:_____

Email: _____

Referring Doctor: _____ **Phone:** _____

Primary Care Doctor:_____ **Phone:**_____

Insurance:

In an area of different insurance policies, our office staff cannot possibly know the terms of your individual policy. Please review your plan booklet or check with your insurance representative if you are unsure whether services at Gastroenterology Specialists of Southwest Florida, P. A are covered under your policy.

You are responsible for knowing if your visit, procedure, or in-office test needs to be pre-authorized by your insurance company.

It is your responsibility to know if we participate with your insurance company, or if you will have to use your out-of-network benefits.

If your insurance plan is terminated after we have checked eligibility or if your employer terminates your coverage retroactively, you will be responsible for the balance.

By printing my initials for the above described policies, I acknowledge and agree to all terms and conditions. _____
Initials

Payments:

Unless other payments are approved by us in writing, your balance is due and payable when your statement is issued and past due if not received within 30 (Thirty) days of the issue date on the statement. Your responsibility will be the amount indicated on your statement under " pay this amount". We reserve the right to add any fees incurred by us for additional billing and collection services. For your convenience, we accept most VISA, MasterCard, Discover, bank debit cards, and personal checks. There is a $15.00 (Fifteen) fee for any returned check by your bank. If necessary, we can set up a regular payment schedule for you. This form acknowledges that you have given us permission to report to your account status to any credit agency such as a credit bureau if the agreed-upon amount is not paid each month. You understand that if your account is submitted to an attorney or collection agency, or results in litigation, or if your past due amount is reported to a credit agency, the fact that you have received treatment services at our office may become a matter of public record. Nonpayment of overdue balances may jeopardize continued care with Gastroenterology Specialist of Southwest Florida, P.A.

By printing my initials for the above described policies, I acknowledge and agree to all terms and conditions. _____

Initials

Appointments:

If you are unable to keep your appointment, kindly give a 24-hour notice. Otherwise, a charge of $60.00 (Sixty) may be applied to your account. Please be advised your insurance will not cover this fee and you will be responsible.

By printing my initials for the above described policies, I acknowledge and agree to all terms and conditions. _____

Initials

Records:

All requests for medical records must be requested in wrtiting with a medical records release form.

You acknowledge and agree to all the terms and conditions contained herein and this agreement will become effective on the date indicated below.

Patient's Name:_____ **DOB:**_____

Signature:_____ **Date:**_____

Patient Consent Form HIPPA Complaint:

With my consent, Gastroenterology Specialists of Southwest Florida, P.A ("The Practice"), may use and disclose protected health information {PHI} about me to carry out treatment, payments, and healthcare operations {TPO} **ONLY**to **family members and/ or friends of my choosing** listed on this form. **This form is not applicable from physician to physician to discuss your treatment.**

I have the right to review this notice of privacy practices prior to signing consent. The practice reserves the right to revise its notice of privacy practices at any time. A revised notice of privacy practices may be obtained by forwarding a written request to the practice to our office address: **1656 Medical Blvd Suite 301 Naples, FL 34110.**

With my consent, the practice may call my home or other designated location and leave a message on my voicemail or in person, in references to any items that assist the practice in carrying out healthcare operations {TPO}, such as appointment reminders, insurance items and any calls pertaining to my medical care, including laboratory results, among others.

With my consent, the practice may mail my home, or other designated location, any items that assist the practice in carrying out healthcare operations {TPO}, such as appointment reminders, patient statements, and others.

I have the right to request that the practice restrict how it uses or discloses my protected health information to carry out healthcare operations. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the practice's use and disclosure of my protected health information {PHI} to carry out healthcare operations {TPO}. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I understand that if I do not list anybody on this consent, the practice WILL NOT disclose any of your protected health information to anybody but you (the patient).

○ **I wish to allow the following person(s) access to my medical records.**

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

○ **I wish NOT to allow anybody but me (the patient) access to my medical records.**

Patient's Name:_____ **DOB:**_____

Signature:_____ **Date:**_____

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Medical Records Release Form:

Authorization of disclosure of protected health information by another covered entity for use by Gastroenterology Specialists of Southwest Florida, P.A.

Requesting to:

Physician's Name: _____

Phone: _____ **Fax:** _____

Address: _____

I authorize the following medical records to be released:

- ○ Office Visits
- ○ Lab Results
- ○ Radiology Reports
- ○ Surgical Reports
- ○ Pathology Reports
- ○ EGD/ Colonoscopy Reports

This authorization shall be in effect for one year. I understand that I have the right to revoke this authorization at any time by sending written notification to the privacy officer at 1656 Medical Blvd Suite 301 Naples, FL 34110.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that I have the right to refuse to sign this authorization.

Please fax to 239-593-6202 (Preferred)
or mail to 1656 Medical Blvd Suite 301, Naples FL 34110

Patient's Name: _____ **DOB:** _____

Signature: _____ **Date:** _____