McKenzie
Gastroenterology Associates

New Patient Medical History Questionnaire

Name:_____

PCP:_____

Chief Complaint/ Reason for visit (In your own words please describe the reason for your visit):

Review of Symptoms: Circle any item you have experience within the past 3 months:

General

Fever or Chills
Malaise
Weakness
Increase in appetite
Decrease in appetite
Night sweats
Weight increase
Weight decrease

Eyes/Ears/Nose/Throat

Eye pain
Change in vision
Hearing loss/ringing in ears
Hoarseness
Neck swelling/lumps
Soreness in mouth
Nose bleeds

Respiratory

Difficulty breathing
Wheezing
Cough
Coughing up blood

Cardiovascular

Chest pain
Leg/ankle swelling
Palpitations
Irregular heartbeat

Gastrointestinal

Abdominal pain
Change in bowel habits
Constipation
Diarrhea
Difficulty swallowing
Bloody or black stool

Urinary

Blood in urine
Difficulty urinating

Female

Pregnant
Heavy menstrual bleeding
Irregular menstrual periods

Neurologic/Mood

Dizziness
Headache
Coordination problems
Numbness
Anxiety
Depression
Increased stress
Memory loss/confusion

Skin/Joints

Rash or Hives
Itching
Hair loss
Back pain/joint pain
Muscle pain/cramps

Hematologic

Easy bleeding
Easy bruising

Immune

Food allergies
Immunosuppression
Seasonal Allergies

Family History

Please check any of the following for parents, siblings, grandparents, aunts, or uncles (indicate maternal or paternal):

- ☐ Ulcerative Colitis:_____
- ☐ Crohn's Disease:_____
- ☐ Colon Polyps:_____
- ☐ Diverticulitis:_____
- ☐ Liver Disease:_____
- ☐ Pancreas Disease:_____
- ☐ Gallbladder disease:_____
- ☐ Ulcers:_____
- ☐ Swallowing disorder:_____
- ☐ GI Bleeding:_____
- ☐ Celiac Disease::_____
- ☐ Anemia:_____
- ☐ Heart attack:_____
- ☐ Coronary artery disease:_____
- ☐ Congestive heart disease:_____
- ☐ Hypertension:_____
- ☐ Atrial fibrillation:_____
- ☐ Blood clots:_____
- ☐ Asthma:_____
- ☐ COPD:_____
- ☐ Cancer:_____
- ☐ Diabetes:_____
- ☐ Thyroid Disease:_____

CONTINUED ON PAGE #2

New Patient Medical History Questionnaire- Page 2

Name:_____ DOB:_____

Social History (Please circle yes or no):

Do you drink alcohol?	Yes or No	If yes, how many drinks per week?_____
Do you use tobacco?	Yes or No	If yes, how many per day?_____ Quit/when_____
Do you drink caffeine?	Yes or No	If yes, how many drinks per day?_____

Surgical History (please check if you have had any of the following surgeries or procedures and list year performed):

☐ Appendix removal:_____	☐ Hernia:_____	☐ Tubal ligation:_____	☐ CT scan:_____
☐ Gallbladder removal:_____	☐ Kidney surgery:_____	☐ Pacemaker:_____	☐ Ultrasound:_____
☐ Heart surgery:_____	☐ Stomach surgery:_____	☐ Splenectomy:_____	☐ X-ray:_____
☐ Colon resection:_____	☐ Gastric bypass:_____	☐ Mastectomy:_____	☐ Blood tests_____
☐ Hysterectomy:_____	☐ Lap band:_____	☐ MRI:_____	☐ Other:_____

Other surgery not listed: _____

Have you ever had an upper endoscopy (EGD)? _____Yes ____No If yes, when? _____

Have you ever had a colonoscopy? ____Yes ____No If yes, when?_____

Allergies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medications (Please list all current medications, dosages, and frequency of use):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Patient Signature: _____ **Date:** _____

PATIENT REGISTRATION FOI

MCKENZIE PHYSICIAN SERVICES, LLC

Patient Information

Name: _____ Date of Birth: _____ Sex: M / F

Guarantor: _____ Relationship to Patient: _____

Social Security Number: _____ Email: _____

Marital Status (Circle one): Married / Single / Divorced / Widow / Partner / Other

Race: _____ Ethnicity: _____ Primary Language: _____

Address: _____
(Street) (City/State/Zip)

Home Phone: (____) _____ Cell: (____) _____ Work: (____)_____

Okay to leave medical information on home voicemail? Yes No
Okay to leave medical information on cell voicemail? Yes No
Okay to leave medical information on work voicemail? Yes No

Preferred Pharmacy: _____ Location: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Care Physician: _____

Release of Information Consent

I authorize McKenzie Physician Services to discuss **ANY** information regarding my care with the below mentioned persons:

Name: _____ Relationship: _____

Primary Contact Number:_____ Secondary Contact Number:_____

Name: _____ Relationship: _____

Primary Contact Number:_____ Secondary Contact Number:_____

Do you have an Advanced Directive? Yes No
Do you have a Power of Attorney? Yes No

By signing below I am acknowledging the above information to be accurate. I understand that in order to revoke my consent to share my medical information with the above individuals, I need to do so in writing.

Name (Please print): _____ Date: _____

Signature: _____

Revised 4/27/16

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**
I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Facility to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**
I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice included in the Notice of Privacy Practices.

3. **NOTICE OF PRIVACY PRACTICES:**
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**
I agree and understand that all physicians (including fellows, residents, physician assistants, nurse practitioners, and interns) involved in my care in any way are responsible and liable for their own acts and omissions, and the facility/practice is not responsible or liable for the acts or omissions of the aforementioned. Services may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Facility.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, fellows, residents, interns, and employees of the Facility. I understand that one or more physicians, fellows, residents, and/or interns at the Facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

Patient Label

5. **CONSENT TO PHOTO/VIDEO :**

_____ *patient initials*

I consent to the photographing or videotaping, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

6. **CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**

☐ Yes ☐ No I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

7. **EMAIL:**

☐ Yes ☐ No I hereby consent to provide my e-mail address, so that representatives from the Facility can e-mail information to me about health education or disease prevention and up-to-date information about the Facility, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

8. **IMAGING SERVICES:**

☐ Please check this box to allow the facility's Imaging Services to share your images with affiliated facilities, when requested, for continuing medical treatment.

9. **CELL PHONES:**

☐ Yes ☐ No I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Facility, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by emailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label