Colorectal Health Northwest

Patient Information

Referring Physician: _____ Today's Date: _____

Primary Care Physician and phone: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ___/___/___ Sex: ☐ M ☐ F Race: _____ Ethnicity: _____

Preferred Language: _____ Would you like an interpreter? ☐ YES ☐ NO

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Email: _____

Please check where we may leave a detailed message. ☐ Home ☐ Cell ☐ Do not leave detailed message

Emergency Contact: _____ Relationship: _____ Phone: _____

May we speak to your emergency contact regarding your health information? ☐ YES ☐ NO

PRIMARY INSURANCE

Insurance Name: _____

Insurance ID #: _____ **Group or Plan #:** _____ **Network:** _____

Policy Holder/Subscriber Name: _____ Relationship: _____ DOB: _____

Claims Address: _____

SECONDARY INSURANCE

Insurance Name: _____

Insurance ID #: _____ **Group or Plan #:** _____ **Network:** _____

Policy Holder/Subscriber Name: _____ Relationship: _____ DOB: _____

Claims Address: _____

RESPONSIBLE PARTY: (Person responsible for payment) ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that I am personally responsible for all charges by my physician, whether or not paid for by insurance, and guarantee payment of the bill. I authorize payment of the medical benefits directly to the physician. I also authorize release of medical or other information to my insurance company.

_____ _____

Signature of Patient or Personal Representative **Date**

Colorectal Health Northwest

Health Questionnaire

☐ Scott Browning ☐ Jeffrey Manchio, MD ☐ Richard Kalu, MD ☐ No Preference

Legal Patient Name _____ Date of Birth _____

Preferred name if different _____

Reason for visit _____

Primary Care Provider Name and Phone:	Referring Provider Name and Phone if not your PCP:

MEDICATIONS: (Please list ALL medications that you are currently taking and their doses. Please include over the counter medications, vitamins, and supplements.

Name of medication	Dose	Name of medication	Dose

Are you allergic to any medications: ☐ NO ☐ YES, please list the medication(s) and reaction(s) below

_____

Preferred Local Pharmacy Name _____ Phone _____

Address _____ City _____ Zip _____

PAST MEDICAL HISTORY: Please list any illnesses or medical problems you have had, and the approximate date

_____

_____

PAST SURGICAL HISTORY: Please list all surgeries you have had and the approximate date they occurred.

_____

_____

PREVIOUS COLON CANCER SCREENINGS: Please list the **year** of your most recent colon screening and the **physician** who performed the test.

☐ Flexible Sigmoidoscopy _____ ☐ Other _____

☐ Colonoscopy _____ **Did you have polyps?** ☐ NO ☐ YES

FAMILY HISTORY: Have any of your family had the following? Please list the relationship and AGE at the time of their diagnosis.

☐ Colon or Rectal Cancer _____ ☐ Colon or Rectal Polyps _____

☐ Crohn's Disease _____ ☐ Ulcerative Colitis _____

SOCIAL HISTORY:

What is your marital status? ☐ Single ☐ Married/Partner ☐ Widowed ☐ Other _____

Occupation? ☐ Retired ☐ Unemployed ☐ Employed/Occupation _____

Do you have children? ☐ NO ☐ YES, how many? _____

Do you have any religious objection to blood transfusions? ☐ NO ☐ YES

Would you like a chaperone during your visit? ☐ NO ☐ YES

Which best describes your smoking status? ☐ Never smoked ☐ Former smoker, year quit _____

☐ Current smoker, qty per day _____

Do you use smokeless tobacco? ☐ No ☐ Yes, type & qty _____

Do you currently use any recreational drugs, including marijuana? ☐ NO ☐ YES, type _____

How often do you drink alcohol? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasional **Drinks per week?** _____

REVIEW OF SYMPTOMS: Please check all symptoms you currently have or have had in the past.

GENERAL
- ☐ Recurrent fever
- ☐ Significant weight change
- ☐ Sweats
- ☐ Anorexia
- ☐ Fatigue
- ☐ Malaise
- ☐ Sleep disorder

EYES, EARS, NOSE & THROAT
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Eye pain
- ☐ Tinnitus
- ☐ Decreased hearing
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Hoarseness

CARDIOVASCULAR
- ☐ Abnormal heart valve
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Peripheral edema
- ☐ High cholesterol
- ☐ Irregular heartbeat

RESPIRATORY
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Cough
- ☐ Sleep apnea/CPAP

ABDOMINAL/GI
- ☐ Hernia
- ☐ Peptic ulcer
- ☐ Difficulty swallowing
- ☐ Reflux
- ☐ Jaundice
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Gas/bloating
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Indigestion/heartburn
- ☐ Constipation
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Bloody BMs
- ☐ Black BMs
- ☐ Fecal incontinence

UROLOGIC/REPRODUCTIVE
- ☐ Frequent urination
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Urinary hesitancy
- ☐ Nocturnal urination
- ☐ Prostate problems
- ☐ Vaginal discharge

MUSCULOSKELETAL
- ☐ Joint swelling
- ☐ Joint pain
- ☐ Arthritis
- ☐ Shoulder pain/hand/wrist
- ☐ Low back pain
- ☐ Muscle weakness
- ☐ Leg pain with exertion

DERMATOLOGIC
- ☐ Rash
- ☐ Itching
- ☐ Hives
- ☐ Skin cancer
- ☐ Non-healing ulcers

NEUROLOGIC
- ☐ Seizure
- ☐ Fainting/blackouts
- ☐ Stroke
- ☐ Paralysis
- ☐ Tremors
- ☐ Frequent headaches
- ☐ Difficulty walking
- ☐ Sciatica
- ☐ Confusion
- ☐ Memory loss

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Steroid use

HEMATOLOGIC
- ☐ Bruising
- ☐ Bleeding
- ☐ Blood thinner use

ONCOLOGIC
- ☐ Radiation
- ☐ Chemotherapy

HEIGHT _____ **WEIGHT** _____

Colorectal Health Northwest

Patient Confidential Communication Consent

Your privacy is our most important goal. Many of our patients allow family members, caregivers, or others to request medical or billing information on their behalf. Federal law requires that your information may not be shared with anyone, unless law allows it or permission has been given. By signing this form you agree to share your Protected Health Information (PHI) with the individuals named below.

Please note: Anyone listed below as having permission to have access to your Protected Health Information (whether on paper, electronic, or verbal) will have access that may include specially protected records (i.e. HIV results) ORS333-022-0210.

I authorize the following person(s) to discuss, receive written documents and/or have access to my Athena Patient Portal account with all my personal health information, which includes billing/financial and insurance information, appointments, and all health information and treatments.

1) _____ Relationship _____ Phone _____

2) _____ Relationship _____ Phone _____

3) _____ Relationship _____ Phone _____

4) _____ Relationship _____ Phone _____

- I understand I must sign a separate medical records release authorization to release copies of my medical record to another individual.
- I understand I have the right to revoke my permission at any time except where Colorectal Health NW has already made disclosures in reliance upon prior requests. I understand this permission remains in effect until the time I revoke it in writing.

_____ _____

Patient Name - Please print **Date of Birth**

_____ _____

Signature of Patient or Guardian **Date**

Name and Relationship of Guardian _____