Duke Gastroenterology of Raleigh

New Patient Form

Date: _____ Name: _____ Date of Birth: _____ Telephone Number: _____

Address: _____ Email: _____

Referring physician: _____ Primary care physician: _____

What is the reason for your visit? _____ How did you hear about our practice? _____

☐Chronic Cough ☐Coughing up Blood ☐Chest Pain ☐ Shortness of Breath ☐History of Asthma ☐History of COPD

☐History of Emphysema ☐ Other: _____

☐ My physician referred me because my blood tests were abnormal or I had abnormal imaging studies (CT Scan, MRI, other)

Are you experiencing any pain? ☐ YES ☐ NO If Yes where is the pain located: _____

Rate the pain on a scale from 1 – 10 (the worse pain): _____ Does anything relieve the pain: _____

When do you experience the pain: _____ Describe the pain: _____

_____

Past Medical History: Which of the following conditions are you currently being treated or have been treated for in the past:

☐ Colon Cancer	☐ Hepatitis A B C	☐ Heart Disease/Arrhythmia/Angina	☐ Asthma
☐ Colon Polyps	☐ Liver Problems	☐ Heart Attack	☐ Emphysema/COPD
☐ Irritable Bowel Syndrome	☐ Bleeding Disorders	☐ Stroke	☐ Chronic Cough
☐ Crohn's Disease	☐Anemia	☐ Kidney Disease	☐ Arthritis
☐ Ulcerative Colitis	☐ High Blood Pressure	☐ Diabetes	☐ Cancer Type: _____
☐ Stomach Ulcers	☐ Heart Disease	☐ Seizures	☐ Other: _____

Other: _____

Please list your hospitalizations and surgeries with approximate year:

_____

_____

_____

Have you ever had a reaction to anesthetic? ☐Yes ☐No If yes, please describe: _____

Are you allergic to Latex? ☐Yes ☐No Do you have any drug allergies? ☐Yes ☐No

If **YES**, please list allergies: _____

Please complete the reverse side

Social and Preventive History:

Employment/Occupation_____ ☐ Single ☐ Married ☐ Divorced ☐ Life Partner/Significant Other ☐ Widow

Do you currently smoke/chew tobacco? ☐ Yes ☐ No Year Started _____ Are you still smoking? ☐ Yes ☐ No

If No, what year did you quit smoking: _____

How many alcohol drinks do you have per: _____ DAY/WEEK (circle)

Other drug use? ☐ Yes ☐ No If Yes Please List: _____

Have you fallen in the last 6 months? ☐ Yes ☐ No How many times: ____ Do you need assistance with standing or walking? ☐ Yes ☐ No

Do you use any assistive devices to walk? ☐ Walker ☐Cane ☐Crutches ☐

Do you have any concerns about your health or well being that we need to discuss today? ☐ Yes ☐ No

If Yes Please Explain: _____

Are you currently living in an abusive situation? ☐ Yes ☐ No If Yes Please Explain: _____

Are you currently working with social services concerning your abusive situation? ☐ Yes ☐ No If yes Please List Services: _____

Family Medical History

Please check and list the family member with the diagnosis: Mother, Father, Sister/Brother, Aunt/Uncle and Grandparents

☐ Colon Cancer_____ ☐ Crohn's Disease _____ ☐ Hypertension_____

☐ Colon Polyps_____ ☐ Ulcerative Colitis_____ ☐ Heart Disease (CAD) _____

☐ Cirrhosis of the Liver _____ ☐ Celiac Sprue _____ ☐ High Cholesterol _____

☐ IBS _____ ☐ Stomach Cancer_____ ☐ Stroke _____

☐ Peptic Ulcer Disease_____ ☐ Other Liver Disease_____ ☐ Alcoholism or other substance abuse_____

☐ Other_____ ☐Diabetes_____

Review of Systems – Please check the symptoms you have been experiencing recently:

General: ☐weight loss ☐fatigue ☐weakness ☐fever ☐chills ☐night sweats

HEENT: ☐ vision changes ☐ hearing loss ☐ ringing in the ears ☐ nose bleeds

Neck: ☐ pain/difficulty swallowing ☐ sore throat ☐lumps/masses in neck ☐ hoarseness

Respiratory: ☐ shortness of breath ☐ wheezing ☐ dry cough ☐ productive cough ☐ coughing up blood

Cardiac: ☐ palpitations ☐ chest pain ☐ short of breath with exercise ☐ swelling in legs ☐ short of breath when lying down

GI: ☐ nausea ☐ vomiting ☐ difficulty swallowing ☐ indigestion ☐ blood in stools
☐ constipation ☐ diarrhea ☐ change in bowel habits ☐ weight loss ☐ change in the color of stools

GU: ☐ difficulty urinating ☐ pain on urination ☐ prostate problems ☐ urinating multiple times at night ☐ blood in urine

Vascular: ☐ pain in calves when walking ☐ blood clots in legs

Musculoskeletal: ☐ pain/stiffness in bones or joints ☐ arthritis ☐ gout ☐ muscle weakness

Neurologic: ☐ numbness/weakness ☐ tingling ☐ tremors ☐ seizures ☐ blackouts ☐ headache

Hematologic: ☐ easy bruising/bleeding

Endocrine: ☐ heat/cold intolerance ☐ excessive thirst

Psychiatric: ☐ depression ☐ anxiety ☐ thoughts of suicide

Skin: ☐ skin ☐ hair or nail changes ☐ rashes ☐ sores ☐ jaundice

Patient Name: _____ Date of Birth: _____

Private Diagnostic Clinic, PLLC
at DUKE UNIVERSITY MEDICAL CENTER

GUIDE FOR ALTERNATIVE MEANS OF COMMUNICATION

Patient Name: _____

Medical Record Number: _____

Date of Birth: _____

Specific Clinic Patient is seen at: _____

The Health Insurance Portability & Accountability Act (HIPAA) requires the Private Diagnostic Clinic, PLLC ("PDC") to have reasonable safeguards in place to protect out patients' health information. In addition, HIPAA requires the PDC to reasonably limit incidental uses or disclosures of our patients' protected health information (medical records), and agree to reasonable requests by our patients to communicate with them by alternative means or at alternative locations.

While we strive to provide our patients with prompt results of clinical and lab tests, the PDC's providers are often asked to disclose the results to spouses, children, significant others, and other medical offices. In addition, some of the PDC's patients prefer to receive messages left on home answering machines or work voice mails. Absent an agreement by a specific PDC clinic or clinical site to the contrary (which shall cover only that particular clinic or clinical site), the PDC reserves the right to use its professional judgment to determine what reasonable actions and safeguards it should take when communicating with its patients and individuals involved in our patients' care. However, to help guide the PDC's judgment, please complete the relevant portions below to help your PDC providers understand what alternative means of communication and disclosures to individuals involved in your care you would prefer so that the PDC providers may use this information to determine reasonable ways to inform you of your test results and other pertinent clinical information.

[ ] Spouse Name/Number: _____

[ ] Significant Other Name/Number: _____

[ ] Child/Children Name/Number: _____

Name/Number: _____

[ ] Work Voice Mail Number: _____

[ ] Answering Machine Number: _____

[ ] Dr. Office Name/Number: _____

_____

[ ] Other _____

This form shall be used as a guide by the PDC providers, and it is not to be an agreement by the PDC to accept any restrictions or protections of the patient's protected health information requested by the patient or the patient's personal representative. In addition, this form is not a conclusive determination by the PDC that your requests for communications by alternative means or at alternative locations are reasonable. Further, this form shall be used only by the particular clinic or clinical site listed herein.

By completing this form, you are allowing the clinical and clerical staff as well as the physicians of Duke GI of Raleigh to discuss your medical information, appointment dates and insurance issues with the persons listed above.