

ValleyCare Gastroenterology Medical Group, Inc.

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5575 West Las Positas Blvd., Suite 320, Pleasanton, CA. 94588

Patient Information

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #1: _____ #2 Home or Cell: _____

Email: _____ Date Of Birth: _____

Occupation: _____ Employer: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Were you referred to our office? YES / NO

Referring Doctor: _____ Primary Care Physician: _____

Insurance Information

Primary Insurance Carrier: _____ Subscriber: _____ Date of Birth: _____

Secondary Insurance Carrier: _____ Subscriber: _____ Date of Birth: _____

Consent for Treatment/Insurance Authorization

I hereby authorize the release of information to my insurance company concerning charges/treatment provided to me by the physicians of ValleyCare Gastroenterology Medical Group, Inc. Transmittal by fax is authorized. I hereby assign benefits and I understand that payment is due as services are provided, including my deductible, co-payment, coinsurance, or any balance not paid by my insurance (excluding contractual allowance). If, after 60 days, insurance payment has not been received, I understand that the charges are my responsibility and payable immediately. Additionally, I understand that I am responsible for providing the referral from my primary care physician. In event that such a referral has not been provided to ValleyCare Gastroenterology Medical Group, I agree to pay for services at the time they are rendered.

Year 1. _____
Patient Signature Date

Year 2. _____
Patient Signature Date

Year 3. _____
Patient Signature Date

I have read and understand the financial policies and I agree to comply with them. I attest that all information given is true and accurate to the best of my knowledge.

Patient Signature

Date

VALLEYCARE GASTROENTEROLOGY MEDICAL GROUP, INC

Phillip Wolfe, MD Perrin D. Royea, PA-C
5575 W Las Positas Blvd, Suite 320, Pleasanton, CA 94588
Phone 925-460-8167 Fax 925-460-0246

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:

Contact Preference

Cell Ph# Home Ph# Patient Portal Patient declines to specify Other:

Race

Select one or more

White Black or African American Asian American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
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

Sex

Male Female Other

Preferred Language

English Patient declines to specify

Allergies

Patient has no known allergies Patient has no known drug allergies
Penicillins Codeine Sulfate Sulfa (Sulfonamide Antibiotics) Other: Other:

Current Medications

None

Table with 3 columns: Name, Dose, How taken? containing multiple rows for medication entry.

Pharmacy

Name _____ Address _____ Phone _____

Immunizations

- None
- Up to date unknown if up to date Other: _____ Other: _____ Other: _____

Diagnostic Studies/Tests

- None
- Colonoscopy Endoscopy Blood test/labs Other: _____ Other: _____
- When: _____ When: _____ When: _____

Past or Present Medical Conditions

- None
- | | | | | |
|--|---|---|---|---|
| <input type="radio"/> High blood pressure | <input type="radio"/> Heart Murmur | <input type="radio"/> Heart attack/angina | <input type="radio"/> Breast cancer | <input type="radio"/> Other Cancer |
| <input type="radio"/> Elevated cholesterol | <input type="radio"/> Enlarged Prostate (BPH) | <input type="radio"/> Hypothyroidism | <input type="radio"/> Diabetes | <input type="radio"/> Anxiety disorder |
| <input type="radio"/> Colon polyps | <input type="radio"/> Colon cancer | <input type="radio"/> Bleeding disorder | <input type="radio"/> Chronic Lung Disease | <input type="radio"/> Barrett's Esophagus |
| <input type="radio"/> Ulcer | <input type="radio"/> Ovarian cancer | <input type="radio"/> Blood clot/DVT/PE | <input type="radio"/> Emphysema | <input type="radio"/> Celiac disease |
| <input type="radio"/> Depression | <input type="radio"/> Prostate cancer | <input type="radio"/> Stroke | <input type="radio"/> Pacemaker/Defibrillator | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Hepatitis A | <input type="radio"/> Hepatitis B | <input type="radio"/> Hepatitis C | <input type="radio"/> Pancreatitis | <input type="radio"/> Esophageal cancer |
| <input type="radio"/> Skin cancer | <input type="radio"/> Transfusions | <input type="radio"/> Anemia | <input type="radio"/> Liver cancer | <input type="radio"/> Asthma |
| <input type="radio"/> Gerd-Acid Reflux | Other: _____ | | | |

Previous Procedures

- None
- | | | | | |
|---|---|--|---|--|
| <input type="radio"/> Appendectomy | <input type="radio"/> Cholecystectomy (gallbladder surgery) | <input type="radio"/> Hernia Repair | <input type="radio"/> Heart surgery | <input type="radio"/> Pacemaker/auto defibrillator |
| <input type="radio"/> Tonsillectomy | <input type="radio"/> Carpal tunnel surgery | <input type="radio"/> Joint surgery (knee, shoulder arthroscopy) | <input type="radio"/> Joint replacement | <input type="radio"/> Gastric bypass |
| <input type="radio"/> Hysterectomy | <input type="radio"/> C-section | <input type="radio"/> Plastic surgery | <input type="radio"/> Tubal ligation | <input type="radio"/> D and C |
| <input type="radio"/> Colon surgery/resection | <input type="radio"/> Surgery _____ | | | |

Social History

Occupation: _____ Number of Children: _____

Marital Status

- Single Married Divorced Separated Widowed
 Civil Union Other

Alcohol

- None
 1 drink/day 2 drinks/day 3-4 drinks weekly Type: _____

Caffeine

- None
 1 cup coffee/day 2 cups coffee/day soda Intake: _____

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
Type: _____

Exercise

- None
 30 minutes daily 20-30 minutes 3-4x/week other Type: _____

Review Of Systems

Gastrointestinal

None Y N

abdominal pain

abdominal swelling

change in bowel habits

constipation

diarrhea

gas

heartburn

jaundice

nausea

rectal bleeding

stomach cramps

vomiting

difficulty swallowing

Constitutional

None Y N

fatigue

fever

loss of appetite

body aches

sweats

weight gain

weight loss

help: walking, dressing

Cardiovascular

None Y N

chest pain

difficulty breathing with exercise

irregular heart beat

palpitations

leg/ankle swelling

Respiratory

None Y N

asthma

cough

shortness of breath

excessive sputum

coughing up blood

wheezing

ENMT

None Y N

dizziness

ear pain

nose bleeds

sore throat

hearing loss

Eyes

None Y N

double vision

loss of vision

sensitivity to light

Genitourinary

None Y N

dark urine

decrease in urine flow

dysuria

frequent urinary infections

frequent urination

blood in urine

impotence

frequent urination at night

urinary incontinence

prostate problem

penile discharge

hysterectomy/menopause

irregular periods

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

Integumentary

None Y N

allergies

dryness

hives

itching

jaundice

lesions

rashes

Hematologic/Lymphatic

None Y N

swollen glands/lymph nodes

easy bruising

prolonged bleeding

Endocrine

None Y N

excessive thirst

hair loss

heat intolerance

Allergic/Immunologic

None Y N

HIV exposure

persistent infections

strong allergic reactions or urticaria/hives

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

Yes No

Consent to Share Data

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

Yes No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature

Date

