Benrus Surgical
at Barnes Jewish St. Peters

Patient History
Dr. Miller Patients

ALL QUESTIONS MUST BE ANSWERED

Name: _____ Age:_____ Date:_____ DOB: _____
What is your primary problem? How long has it been going on? _____
_____
Who is your Primary Care Doctor: _____ Referring Doctor: _____
Please indicate if you have had any of the following:

Rectal pain	Y/N	Constipation	Y/N
Rectal bleeding	Y/N	Diarrhea	Y/N
Itching/Burning	Y/N	Blood in Stool	Y/N
Protrusion/Swelling	Y/N	Change in bowel habits	Y/N
Discharge	Y/N	Fecal Incontinence	Y/N
Abdominal Pain	Y/N	Diverticulosis	Y/N
Nausea	Y/N	Vomiting	Y/N

Have you had a Colonoscopy? _____ When?/Where?_____
How often do you move your bowels? _____
Do you need to take antibiotics before surgical or dental procedures? Why?_____
Have you ever been treated for the following: Chlamydia: Y/N Gonorrhea: Y/N
Syphilis: Y/N Venereal Warts: Y/N Herpes: Y/N HIV/AIDS: Y/N Hepatitis: Y/N
Have you ever received Radiation Therapy or Radiation Seeds for any reason such as prostate cancer or Cervical cancer? Explain? Y/N _____

Current Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies (meds, Latex)

_____
_____
_____
_____
_____

Social History: Tobacco Y/N Amount? _____
Alcohol Y/N Amount? _____

Surgical History

_____
_____
_____
_____
_____

Medical/Family History:
(Do you or your family have any of the following problems?)

	Patient	Family
Colon Cancer	___	___
Colon Polyps	___	___
Ulcerative Colitis	___	___
Crohns disease	___	___
Other cancers	___	___
Heart Disease	___	___
Hypertension	___	___
Diabetes	___	___
Stroke	___	___
Lung Disease	___	___
Liver Disease	___	___
Kidney Disease	___	___
Blood clotting problems	___	___

Review of Systems

General	Weight loss	Y/N
	Sleep Apnea	Y/N
Neurologic	Dizziness	Y/N
	Light-headed	Y/N
	Weakness	Y/N
Eyes	Vision changes	Y/N
ENT	Hearing changes	Y/N
Cardiac	Chest Pain	Y/N
	Chest pressure	Y/N
	Tightness	Y/N
	Palpitations	Y/N
Respiratory	Shortness of Breath	Y/N
	Coughing	Y/N
	Wheezing	Y/N
Urinary tract	Frequent urination	Y/N
	Burning	Y/N
	Inability to urinate	Y/N
Musculoskeletal	Leg swelling	Y/N
Lymph	Swollen glands	Y/N
Hematologic	Easy bruising	Y/N
Skin	Rashes	Y/N

Physician Signature_____

BJC Medical Group

Name: _____
DOB: _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES AND HIPAA DISCLOSURE AUTHORIZATION

Receipt of Notice of Privacy Practices

Initial _____ I acknowledge I have received or I have been provided the opportunity to receive a copy of BJC's Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by BJC Medical Group.

HIPAA Disclosure Authorization(s)

I authorize BJC Medical Group to:

Initial _____ Contact me at the following number(s): _____

Initial _____ Leave a voice message with me at the following number(s): _____

Initial _____ Provide the following person(s) with my protected health information:

Print Name: _____ Relationship to Patient/Phone number: _____

Print Name: _____ Relationship to Patient/Phone number: _____

I do not authorize BJC Medical Group to:

Initial _____ Disclose my protected health information to anyone other than myself, except as permitted by HIPAA and as described in BJC's Notice of Privacy Practices.

HIPAA Unencrypted Communication Authorizations

Electronic mail (email) and text messaging are common forms of communication, and can be utilized to communicate with your physician and your care team. It is important for you to understand that unencrypted email and text messaging are not secure communications. This means there is a potential risk that messages containing your protected health information may be intercepted by a third party. Encryption is the process of making information unreadable, unless you have the password or key to decrypt the information. BJC does not encrypt text messages, and we cannot guarantee that all email messages will be encrypted.

By initialing below and signing this authorization, I understand and accept the conditions outlined above. I authorize BJC Medical Group to send unencrypted communications to the email address and/or phone number listed below.

I authorize BJC Medical group to:

Initial _____ Send email to the following address: _____

Initial _____ Send text messages to the following phone number: _____

HIPAA Prescription Authorization(s)

Initial _____ I authorize BJC Medical Group to allow the following person(s) to pick up prescriptions on my behalf

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized. I understand this authorization is valid while I continue to receive services from any BJC Medical Group provider.

_____ _____ _____

Signature of Patient/Personal Representative | Relationship to Patient | Date