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

Height ______

Weight ______

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)	Surgical History

Social History: Tobacco Y/N Amount? __________

Alcohol Y/N Amount? __________

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 ______________________

Pharmacy Name and Phone Number ______________________

Name: ____________________

DOB: ____________________

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.

Patient Communication Preferences

Phone number for voice message(s): ____________________

Cell number for text message(s): ____________________

Email address: ______________________________

HIPAA Disclosure Authorizations(s)

Initial _____ **I authorize BJC Medical Group to provide the following person(s) with my protected health information:**

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

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

or

Initial _____ **I do not authorize BJC Medical Group to:**

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.

Prescription Authorization

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