ColumbiaDoctors

New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Preferred Phone: _____ Email: _____ Gender: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Occupation: _____ Employer: _____

Primary Care Provider (PCP): _____ PCP Phone: _____

PCP Address: _____

Preferred Pharmacy: _____ Pharm Phone: _____

Preferred Pharmacy Address: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:
- ☐ Decline Response
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:
- ☐ Decline Response
- ☐ American-Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other

Preferred Language: _____ ☐ Decline Response

Patient Signature: _____ Date: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____

Patient or Guarantor Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

Patient Name (Print): _____

Patient Signature: _____ Date: _____

If completed by a patient's personal representative, please print and sign below.

Representative (Print): _____ Relationship: _____

Representative Signature: _____ Date: _____

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myColumbiaDoctors Patient Portal Sign Up

Access your personal records securely, 24/7, on a computer, smartphone, or iPad. See brochure for details.

☐ Send me an invitation to join myColumbiaDoctors.
Look for an email invite from noreply@followmyhealth.org and click the Registration link.

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Reason for today's visit: _____

_____

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems	☐ Y	☐ N	Heart Disease/Disorder	☐ Y	☐ N
Arthritis	☐ Y	☐ N	Lung Disorder	☐ Y	☐ N
Bleeding/Clotting Disorder	☐ Y	☐ N	Liver Disease	☐ Y	☐ N
Blood Pressure Disorder	☐ Y	☐ N	Neurological Disorder/Chronic Headaches	☐ Y	☐ N
Blood Transfusion	☐ Y	☐ N	Psychiatric Disorder/Illness	☐ Y	☐ N
Bowel/Stomach Problems	☐ Y	☐ N	Pulmonary Embolism/DVT	☐ Y	☐ N
Cancer	☐ Y	☐ N	Stroke	☐ Y	☐ N
Cholesterol Disorder	☐ Y	☐ N	Seizure or Epilepsy	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Thyroid Disorder	☐ Y	☐ N
Eye Disorder (i.e. Glaucoma, cataract)	☐ Y	☐ N	Urinary/Kidney Disorder	☐ Y	☐ N

Please list any other medical illnesses or problems and provide details for any of the above conditions.

_____

_____

Please list any surgeries you have had and the approximate date.

Procedure	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		☐ Y ☐ N	
Father		☐ Y ☐ N	
Sibling		☐ Y ☐ N	
Other:		☐ Y ☐ N	

Do you currently smoke? ☐ Y ☐ N If no, previously? ☐ Y ☐ N Years smoked _____ Packs/day _____

Do you use other tobacco products? ☐ Y ☐ N Consume alcohol? ☐ Y ☐ N If yes, drinks/week: _____

Do you have any allergies to medications or other substances? ☐ Y ☐ N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis).

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Please list ALL previous physicians who have treated you relevant to your visit (i.e. pulmonologist, oncologist, internist, cardiologist, gastroenterologist, etc...)

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose

Medication Name	Dose

Provider Signature: _____ Date: _____

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Review of Systems

Please indicate ALL that you have experienced within the past 6 – 12 months.

General	☐ None	☐ Fever	☐ Chills	☐ Feeling Poorly
	☐ Feeling Tired	☐ Weight Gain	☐ Weight Loss	
Eyes	☐ None	☐ Eye Pain	☐ Vision Changes	☐ Eyesight Problems
	☐ Dry Eyes	☐ Itchy Eyes		
Ear/Nose/Throat	☐ None	☐ Earache	☐ Loss of hearing	☐ Nose bleeds
	☐ Sinus problems	☐ Sore throat	☐ Hoarseness	
Heart	☐ None	☐ Chest pain	☐ Palpitations	☐ Fast heart rate
	☐ Slow heart rate	☐ Leg swelling	☐ Leg pain, discomfort, fatigue during walking	
Lungs/Breathing	☐ None	☐ Cough	☐ Wheezing	☐ Shortness of breath
	☐ Trouble breathing with exertion		☐ Trouble breathing when lying flat	
Gastrointestinal	☐ None	☐ Abdominal pain	☐ Constipation	☐ Diarrhea
	☐ Heartburn	☐ Nausea	☐ Vomiting	☐ Blood in stool
Bladder	☐ None	☐ Incontinence	☐ Discolored urine	☐ Painful urination
	☐ Pelvic pain	☐ Painful period	☐ Vaginal Discharge	
Skin	☐ None	☐ Acne	☐ Itching	☐ Change in a mole
	☐ Skin lesions	☐ Skin wound	☐ Breast pain	☐ Breast lump
Neurological	☐ None	☐ Confused	☐ Convulsions	☐ Dizziness
	☐ Limb weakness	☐ Loss of memory	☐ Headaches	☐ Difficulty walking
Psychiatric	☐ None	☐ Anxiety	☐ Depression	☐ Change in personality
	☐ Suicidal	☐ Disturbed sleep	☐ Emotional problems	
Endocrine	☐ None	☐ Weak muscles	☐ Feeling weak	☐ Deepening of voice
	☐ Hair loss	☐ Hot flashes		
Hem/Lymph	☐ None	☐ Easy bleeding	☐ Easy bruising	☐ Swollen glands

Additional Bariatric Information

Please circle the appropriate answer or fill in the blank for the following questions:

1) Do you snore? Yes No Don't know If Yes: Nightly? Loudly?
2) Has anyone ever told you that you stop breathing, struggle to breathe or gasp in your sleep? Yes No
3) Do you ever wake up short of breath or gasping? No Rarely Occasionally Frequently
4) Do you have trouble falling asleep more than once a week? Yes No
5) How many times do you usually wake up during the night? 0-1 1-2 2-3 3 or more
6) How many times do you usually urinate during the night? 0-1 1-2 2-3 3 or more
7) What time do you usually get into bed at night (range is OK)? _____ AM PM (Circle one)
8) What time do you usually get out of bed to start your day (range is OK)? _____ AM PM (Circle one)
9) How many hours of total sleep do you average each night? _____ Hours
10) Are you refreshed (not sleepy or tired) when you first get up for the day? Yes No
11) Do you nap **on purpose** during the day?

Never Rarely (<1/mo) Sometimes (1/wk) Frequently (2 or more/wk) Daily

12) Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of the things recently, try to imagine how they would affect you. Use the following scale to choose the most appropriate number to describe how likely you are to doze off or fall asleep in each situation:

0= Would never doze 1= Slight chance of dozing 2= Moderate chance of dozing 3=High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in public (i.e. at a meeting or in a theater)	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without any alcohol	
In a car, while stopped for a few minutes in traffic or when you are taking mass transit	

13) Please write in any other information about your sleep that you think might be important.

Most insurance companies are requesting a diet history before approving surgery. For each weight loss method, please indicate if you have tried it, the number of times you have tried that method, for how long, and the amount of weight lost.

	# of times tried:	From:	To:	Amt. WT. Lost:
Weight Loss Programs:				
Comprehensive Weight Loss Programs:				
Diets:				
Medications:				
Weight Loss Aides:				
Other Weight Loss Methods:				

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Center for Metabolic and
Weight Loss Surgery
161 Fort Washington Avenue
New York, NY 10032
tel 212 305 4000
fax 212 342 1996
www.obesitymd.org

Date:

Private Pay Contract with (Patient name and address, phone #)

Name:

Address:

Phone#:

I _____(Patient Name) agree to enter into a private payment arrangement and to make payment to Nancy Restuccia,MS,RD,CDN for the following services provided during my course of treatment:

1. Bariatric Nutritional Consultation
2. Bariatric Nutritional follow up care

_____ _____

(Patient Name) (Patient signature)

_____

Departmental Representative name and signature & Date signed.