Boone Medical Group - Surgery
1601 E Broadway, Suite 240
Columbia, MO 65201
www.boone.health
Phone: 573.815.8145
Fax: 573.815.3832

NEW PATIENT QUESTIONAIRE

Today's Date:
Primary Care Provider:
Referring Provider:
Please list any other providers who you would like to receive a copy of your surgeon's notes/records from your visit?

Patient Information

Last Name:	First:	Middle:	Mr. Mrs.	Miss Ms.

Date of Birth: / /	Age:	SSN:	Sex: Male Female	(Former name):

Race:		Ethnicity:	Preferred Language:	
☐ Black/African American	☐ White/Caucasian	☐ Hispanic or Latino	☐ English	☐ French
☐ Native American	☐ Hispanic	☐ Non-Hispanic/Latino	☐ Spanish	☐ German
☐ Asian	☐ Spanish American	☐ Other ____________	☐ Chinese	☐ Other:________
☐ Other: __________________				

Home Number: ( )	Cell Number: ( )	Work Number: ( )

Street Address:	City:	State:	ZIP Code:

E-mail Address:
Preferred Pharmacy & Location:

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home number: ( )	Cell/Work Number: ( )
Name of friend or relative:	Relationship to patient:	Home number: ( )	Cell/Work Number: ( )

Do you have a legal guardian ☐ Yes ☐ No

If yes, please list name and contact of you legal guardian: ____

BooneHealth
BOONE MEDICAL GROUP

Boone Medical Group - Surgery

1601 E Broadway, Suite 240
Columbia, MO 65201
www.boone.health
Phone: 573.815.8145
Fax: 573.815.3832

Patient Name: ___________________________ DOB: ______________ Date: _______________

MEDICATION

Please provide a printed medication list
or
List all of your current medications, including over-the-counter and herbal supplements.

☐ NO CURRENT MEDICATIONS

Medication	**Dose**	**Frequency**

Please list any additional medications on the bottom of this sheet or on the back.

ALLERGIES

☐ **NO ALLERGIES**

Medication:	Reaction:

Please list any additional allergies on the bottom of this sheet or on the back.

BooneHealth
BOONE MEDICAL GROUP

Boone Medical Group - Surgery
1601 E Broadway, Suite 240
Columbia, MO 65201
www.boone.health
Phone: 573.815.8145
Fax: 573.815.3832

Patient Name: ____________________________ DOB: _______________ Date: ________________

PERSONAL MEDICAL HISTORY

Please mark if you have or have had any of the following medical conditions;
List any additional medical conditions which you feel your surgeon should be aware of:

☐ **NO MEDICAL HISTORY**

Anemia
Angina (chest pain)
Anxiety
Arthritis
Asthma
Atrial Fibrillation (A.Fib)
BPH (Prostate Problems)
Blood Clots
Cancer –Specify:
____
Celiac Disease
Cerebrovascular Accident (Stroke)
OTHER: _________________

COPD
Coronary Artery Disease (CAD)
Crohn's Disease
Depression
Diabetes
GERD (Acid Reflux)
Liver disease/ problems
High cholesterol
High blood pressure
Irritable Bowel Syndrome (IBS)
OTHER: _________________

Myocardial infarction (heart attack)
Osteoarthritis
Osteoporosis
Peptic Ulcer Disease
Renal Disease (Kidney Disease)
Seizure Disorder
Thyroid Disease
- Overactive
- Underactive

OTHER: _________________

PERSONAL SURGICAL HISTORY

Please list all prior surgeries and the approximate month/year they took place:

☐ **NO PAST SURGICAL HISTORY**

Appendectomy, Yr ____
Back Surgery, Yr ____
Breast Surgery, Yr ____
Type: _______________
Cardiac Surgery, Yr ____
Type: _______________
Carpal Tunnel, Yr ____
Colon Surgery, Yr ____
Cystoscopy, Yr ____
C-Section, Yr ____
Eye Surgery, Yr ____

Hernia Repair, Yr ____
Type: _______________
Gallbladder, Yr ____
Kidney Removal, Yr ____
Hip Replacement ---
LEFT OR RIGHT, Yr ____
Hysterectomy, Yr ____
Kidney Stone, Yr ___
Knee Surgery;
LEFT OR RIGHT, Yr ___
Knee Replacement;
LEFT OR RIGHT, Yr ___

Pacemaker, Yr ____
Shoulder Surgery
LEFT OR RIGHT, Yr ___
Tonsils/Adenoids, Yr ____
Tubal Ligation, Yr ____
Other: _________________
- Yr _____

Other: _________________
- Yr _____

Other: _________________
- Yr _____

BooneHealth
BOONE MEDICAL GROUP

Boone Medical Group - Surgery
1601 E Broadway, Suite 240
Columbia, MO 65201
www.boone.health
Phone: 573.815.8145
Fax: 573.815.3832

Patient Name: ___________________________ DOB: ______________ Date: _______________

FAMILY MEDICAL HISTORY

Relationship	Arthritis	Asthma	COPD	Diabetes	Early Death (Before age 60)	Deafness	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Mental Illness (Depression/Anxiety)	Mental Retardation	Stroke	Blindness	Breast Cancer	Colon Cancer	Stomach Cancer	Cancer - Specify	A.Fib	Liver Disease	Seizures	Other	Other
Mother																							
Father																							
Sister																							
Brother																							
Daugther																							
Son																							
Maternal G-mother																							
Maternal G-father																							
Paternal G-mother																							
Paternal G-father																							

SOCIAL HISTORY

Marital Status: Single / Married / Divorced / Separated / Widowed

Children: ☐ YES ☐ NO
Number of Children: _________

Employment Status: Full-time / Part-Time / Self Employed / Retired / Not employed

Employer:

Occupation:

Do you use tobacco? ☐ YES ☐ NO ☐ IN THE PAST
__Cigarette __Cigars __Vapor __Chew

Do you drink alcohol? ☐ YES ☐ NO ☐ IN THE PAST
How many drinks per week? _________

Do you use recreational drugs? ☐ YES ☐ NO
☐ IN THE PAST TYPE: ___________________

Are you sexually active? ☐ YES ☐ NO
Do you use contraception? TYPE:_____________

BooneHealth
BOONE MEDICAL GROUP

Boone Medical Group - Surgery

1601 E Broadway, Suite 240
Columbia, MO 65201
www.boone.health
Phone: 573.815.8145
Fax: 573.815.3832

Patient Name: ___________________________ DOB: ______________ Date: _______________

General Review of Systems

Please read carefully below and check the box if you are currently having any of these symptoms:

NOT CURRENTLY HAVING ANY OF THE LISTED SYMPTOMS

Chills
Fatigue
Fever

Rash
Itching

Ear Pain
Eye Pain
Sore Throat

Chest Pain
Chest Palpitations
Leg Swelling

Cough
Shortness of Breath
Wheezing

Nausea
Vomiting
Abdominal pain

Diarrhea
Constipation
Blood in stool

Pain with Urination
Blood in Urine
Urinary Urgency
Urinary Frequency

Back Pain
Neck Pain
Muscle Weakness

Easy Bleeding
Easy Bruising

Dizziness
Seizures
Headache
Tremors

Anxiety
Depression
Trouble sleeping (insomnia)

Boone Medical Group - Surgery

1601 E Broadway, Suite 240
Columbia, MO 65201
www.boone.health
Phone: 573.815.8145
Fax: 573.815.3832

Patient Name: ___________________________ DOB: ______________ Date: _______________

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):

________ (Initial) I authorize BJC Medical Group to leave a message on my voicemail at the following phone number(s):____.

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

Print Name: ________________________________ Relationship to Patient: _________________

Print Name: ________________________________ Relationship to Patient: _________________

Print Name: ________________________________ Relationship to Patient: _________________

________ (Initial) I **DO NOT** authorize BJC Medical Group to disclose my protected health information to anyone other than myself, except as permitted by HIPAA as described in BJC's Notice of Privacy Practices.

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.

____ _______________

Signature of Patient or Guardian **Date**

____

Relationship to Patient, if signed by someone other than patient

Boone Medical Group - Surgery

1601 E Broadway, Suite 240
Columbia, MO 65201
www.boone.health
Phone: 573.815.8145
Fax: 573.815.3832

Authorization for Release of Information

Fax or mail information to:

Boone Medical Group - General Surgery
1601 E. Broadway, Suite 240
Columbia, MO 65201
Phone Number: 573-815-8145
Fax Number: 573-815-3832

By signing below, I acknowledge and agree that:

- I understand that neither BJC HealthCare nor any of its affiliated healthcare providers can make me sign this Authorization as a condition to getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. I agree that I have received a signed copy of this Authorization if I chose to do it.
- I understand I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This authorization will expire one (1) year from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand if I want to cancel/revoke this Authorization, I must mail, fax or bring a letter in person stating that I want to cancel this Authorization.
- If I am signing on behalf of a patient for whom I am the legal guardian or personal representative, I must attach a certified copy of my appointment as legal guardian or personal representative.

____ ____________________

Signature of Patient/Legal Guardian/Personal Representative **Date**

____

Print Name

____

Relationship to Patient (If someone else signs on behalf of the patient, state your relationship to patient)

____ ____________________

Witness **Date**

BJC Medical Group Use Only

Date Request Granted:

____

Other Disposition (Date/Action):

____