CARL WEBER, M.D.
PHILIP WEBER, M.D.
RAFIK EL-SABROUT, M.D.

WP HOSPITAL physician associates

KAARE WEBER, M.D.
KIMBERLY YEE, M.D.

## Patient Demographics

Patient's Last Name _____ First Name _____ Middle Initial _____

SSN _____ Date of Birth _____ Age _____ Gender F M

Address _____ Apt. # _____ City _____ State _____ Zip _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ White
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer Preferred Language: _____

Marital Status: ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Separated Student Status ☐FT ☐PT

Home Phone _____ Day Phone _____

Email Address _____ Cell Phone _____

Employer _____ Occupation _____ ☐Retired?

Employer Address _____

Emergency Contact _____/_____ Phone _____
Name Relationship

***Primary Care Physician*** Name: _____ Phone:_____

***Referring Physician*** Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

***Primary*** Insurance Coverage: _____

Policy Holder Name: _____ SSN:_____ DOB:_____

***Secondary*** Insurance Coverage: _____

Policy Holder Name: _____ SSN: _____ DOB: _____

This visit is covered by: ☐ No Fault Insurance ☐ Workers' Compensation _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature _____ Date_____

Responsible Party Name _____ Relationship _____

## Patient History Form

**Name:** _____ **Date of Birth:** _____

**Reason for Visit:** _____

_____

| **Please List All Current Medications** | | | ☐ **Not Currently Taking Any Medications** | | |
|---|---|---|---|---|---|
| Medication Name | Dosage | How Often Taking | Medication Name | Dosage | How Often Taking |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| **Allergies (e.g. medication, latex, egg, shellfish)** | | ☐ **No Known Allergies** | |
|---|---|---|---|
| Allergen | Type of Reaction | Allergen | Type of Reaction |
| | | | |
| | | | |
| | | | |

## Review of Systems

| **CONSTITUTIONAL** | | | **GASTROINTESTINAL** | | | **NEUROLOGICAL/PHYCHIATRIC** | | |
|---|---|---|---|---|---|---|---|---|
| ☐ No | ☐ Yes | Chills | ☐ No | ☐ Yes | Abdominal Pain | ☐ No | ☐ Yes | Headaches |
| ☐ No | ☐ Yes | Fatigue | ☐ No | ☐ Yes | Bloating | ☐ No | ☐ Yes | Tremors |
| ☐ No | ☐ Yes | Fever | ☐ No | ☐ Yes | Blood in Stool | ☐ No | ☐ Yes | Weakness |
| ☐ No | ☐ Yes | Night Sweats | ☐ No | ☐ Yes | Changes in Bowel Habits | ☐ No | ☐ Yes | Paralysis |
| ☐ No | ☐ Yes | Weight Loss | ☐ No | ☐ Yes | Constipation | ☐ No | ☐ Yes | Convulsions |
| **HEENT** | | | ☐ No | ☐ Yes | Diarrhea | ☐ No | ☐ Yes | Seizures |
| ☐ No | ☐ Yes | Double Vision | ☐ No | ☐ Yes | Fecal Incontinence | ☐ No | ☐ Yes | Psychiatric Disorder |
| ☐ No | ☐ Yes | Visual Loss | ☐ No | ☐ Yes | Nausea | **DERMATOLOGIC** | | |
| ☐ No | ☐ Yes | Hearing Loss | ☐ No | ☐ Yes | Rectal Bleeding | ☐ No | ☐ Yes | Rash |
| ☐ No | ☐ Yes | Ringing in Ear(s) | ☐ No | ☐ Yes | Reflux | ☐ No | ☐ Yes | Skin Lesion(s) |
| ☐ No | ☐ Yes | Nasal Congestion | ☐ No | ☐ Yes | Vomiting | **MUSCULOSKELETAL** | | |
| ☐ No | ☐ Yes | Difficulty Swallowing | ☐ No | ☐ Yes | Black Stool | ☐ No | ☐ Yes | Back Pain |
| ☐ No | ☐ Yes | Pain w/ Swallowing | ☐ No | ☐ Yes | White Stool | ☐ No | ☐ Yes | Bone/Joint Pain |
| **RESPIRATORY** | | | ☐ No | ☐ Yes | Regurgitation | ☐ No | ☐ Yes | Muscle Pain |
| ☐ No | ☐ Yes | Coughing | **GENITOURINARY** | | | ☐ No | ☐ Yes | Muscle Weakness |
| ☐ No | ☐ Yes | Shortness of Breath | ☐ No | ☐ Yes | Frequent Urination | **HEMATOLOGIC** | | |
| ☐ No | ☐ Yes | Painful Respiration | ☐ No | ☐ Yes | Decreased Urine Stream | ☐ No | ☐ Yes | Easy Bleeding |
| **CARDIOVASCULAR** | | | ☐ No | ☐ Yes | Urinary Incontinence | ☐ No | ☐ Yes | Easy Bruising |
| ☐ No | ☐ Yes | Chest Pain | ☐ No | ☐ Yes | Dark Tea Colored Urine | ☐ No | ☐ Yes | Abnormal Clotting |
| ☐ No | ☐ Yes | Dyspnea on Exertion | **METABOLIC/ENDOCRINE** | | | **PSYCHIATRIC** | | |
| ☐ No | ☐ Yes | Edema (swelling) | ☐ No | ☐ Yes | Cold Intolerance | ☐ No | ☐ Yes | Psychiatric Disorder |
| ☐ No | ☐ Yes | Orthopnea | ☐ No | ☐ Yes | Heat Intolerance | | | |
| ☐ No | ☐ Yes | Irregular Heartbeat | ☐ No | ☐ Yes | Increasing thirst | | | |
| | | Syncope (fainting) | ☐ No | ☐ Yes | Increasing appetite | | | |

Patient Name: _____ Date of Birth: _____

| Past Medical History | | | | | |
|---|---|---|---|---|---|
| ☐ | Anemia | ☐ | Crohn's Disease | ☐ | Prostatitis |
| ☐ | Anesthesia Reaction | ☐ | Deep Vein Thrombosis | ☐ | Hernia |
| ☐ | Arthritis | ☐ | Diabetes | ☐ | Polyps (rectal, colon, etc) |
| ☐ | Asthma | ☐ | Elevated Lipids | ☐ | Anaphylaxis |
| ☐ | Cancer (current or history of) Location(s): | ☐ | GERD | ☐ | TIA ("mini stroke") |
| | | ☐ | Hypertension | ☐ | Heart Murmur |
| | | ☐ | Inflammatory Bowel Disease | ☐ | Tuberculosis |
| | | ☐ | MRSA | ☐ | Emphysema |
| | | ☐ | Heart Attack (MI) | ☐ | Ulcerative Colitis |
| ☐ | Other: | ☐ | Renal Disease | ☐ | Kidney Stones |
| | | ☐ | Seizure Disorder | ☐ | Chronic UTIs |
| | | ☐ | Stroke | ☐ | Ulcers |
| | | ☐ | Thyroid Disease | | |

## Past Surgical History

**Please list all past surgical procedures:** ☐ **No Surgical History**

| Surgical Procedure | Year | Surgeon |
|---|---|---|
| ☐ **Colonoscopy** | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Family History

☐ None ☐ Unknown/Adopted

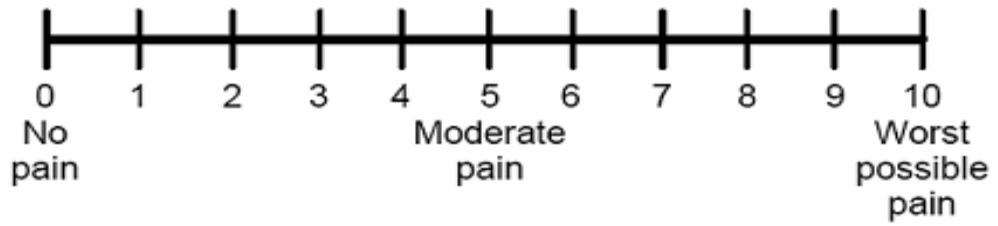
| | | |
|---|---|---|
| ☐ Colon Cancer | ☐ Hypertension | ☐ Diabetes |
| ☐ Polyps (rectal, colon, etc) | ☐ Stroke | ☐ Heart Attack |
| ☐ Blood Disorder | ☐ Thyroid Disorder | ☐ Peripheral Vascular Disease |

☐ Other:

Patient Name: _____ Date of Birth: _____

| Social History | | |
|---|---|---|
| Smoking Tobacco Use History (all patients age 13 and older): | | If there is a history of tobacco use: |
| ☐ Never Smoker | ☐ Current Every Day Smoker | Years Used: _____ |
| ☐ Former Smoker | ☐ Current Some Day Smoker | Usage Per Day:_____ |
| ☐ Unknown if Ever Smoker | ☐ Smoker Current Status Unknown | Age Stopped:_____ |
| Do You Consume Alcohol? ☐ No ☐ Yes ☐Former Frequency: _____ Amount: _____ | | |
| Have you had any falls in the last year? ☐ Yes ☐ No If Yes, please state the number of falls: _____<br><br>Did the fall(s) result in injury? ☐ Yes ☐ No | | |

Please indicate (circle) your current pain scale in relation to your current condition:




Cardiologist's Name: _____ Phone: _____

Endocrinologist's Name: _____ Phone: _____

Gastroenterologist's Name: _____ Phone: _____

Pulmonologist's Name: _____ Phone: _____

Oncologist's Name: _____ Phone: _____

Other Specialist's Name: _____ Phone: _____

Patient Signature: _____ Date: _____

Patient Representative Signature:_____ Relationship: _____