SAINT AGNES HEALTHCARE

Steven C. Cunningham, MD, *443-574-8500*

Name _____ Social Security # _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Sex _____ Marital Status _____

Home Phone # _____ Work Phone # _____ Cell# _____

Employer _____ Occupation _____ Race: _____

Employed: __ Full Time __ Part Time __ Retired Student: __ Full Time __ Part Time

Person to Notify in an Emergency _____

Relationship _____ Phone Number _____

Primary Care Physician _____ Referring Physician _____

Insurance Information:

Primary Insurance _____

Are you the policyholder? _____Yes _____No (*this information is NOT on the card*)
If not, policyholder's name? _____ Relationship to Patient _____
Policyholder Date of Birth _____ Policyholder Employer _____

Secondary Insurance _____

Are you the policyholder? _____Yes _____No
If not, policyholder's name? _____ Relationship to Patient _____
Policyholder Date of Birth _____ Policyholder Employer _____

Insurance Authorization & Information Release

I hereby authorize St. Agnes Healthcare to release information from my records to persons who have need for this information such as insurance companies, doctors, and other agencies or professionals involved in my care. St. Agnes Healthcare personnel are authorized to determine which persons or agencies are in need of such information. I hereby authorize Medicare, Medicaid and/or any insurance company(s) to pay St. Agnes Healthcare directly for services provided. I agree to accept financial responsibility for services provided at St. Agnes Healthcare for the patient.

Signature: _____Date:_____

Notice of Privacy Practices/Financial Policy Receipt: I hereby acknowledge that I have received a copy of the St. Agnes Healthcare Joint Notice of Privacy Practices & the Maryland Surgeons Financial Policy.

Signature: _____Date:_____

MARYLAND SURGEONS

Date_____

ASSIGNMENT AND RELEASE:
I hereby assign my insurance benefits to be paid directly to the physician.
I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
I authorize the physician to release any medical information required to process this claim.
I authorize my provider's office to contact me by telephone to remind me of my appointments.
I authorize Saint Agnes Health to download my current medications for purposes of insurance payment.
I have received a Notice of Privacy Practice, Notice of Patient Rights and Responsibilities
I hereby consent to treatment by my Saint Agnes Health provider(s). I authorize Saint Agnes Health to release to referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continued care and as needed to process claims and for general healthcare operations, which may include use of an electronic health information exchange
I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any re-disclosures of my health information by a third party may no longer be protected under federal or state privacy laws I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.
I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the Practice. However, any disclosures that occured prior to the date of the revocation will not be affected.

By signing this consent, I authorize___St Agnes Healthcare_____ and its affiliates to disclose my protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name:_____ Relationship:_____

Method of Communication:_____

Name:_____ Relationship:_____

Method of Communication:_____

May we contact you regarding your protected health information, health status, appointments, and test results?

_Yes, you may contact me by e-mail; my address is:_____

_No, do not contact me by email for this purpose.

_Yes, you may contact me by phone; my daytime phone numbers are:
( )_____-_____ ( )_____-_____

_Yes, you may contact me at the following fax number ( )_____-_____
May we leave a message regarding your protected health information at the numbers you provided above?
__Yes __No

Signed_____ **Date:**_____

Steven C. Cunningham, MD, FACS
Director of Pancreatic & Hepatobiliary Surgery
Saint Agnes Hospital Center Angelos Medical Pavilion
3407 Wilkens Avenue, Suite 410 , Baltimore, MD 21229
Tel: 443-574-8500; Fax: 410-719-0094; Cell 443-814-6773
Steven.Cunningham@StAgnes.org

SAINT AGNES HOSPITAL

Addressograph

New Patient Medical History Form

Welcome!

Name: _____ **DOB and age:** _____ **Date:** _____

How are you feeling today? _____ **Reason for referral:** _____

Referring or other doctor(s): _____

Symptoms (circle all that apply): Pain Nausea Bulge or mass Diarrhea Bleeding Itching None
Other: _____ Symptoms started on: _____
Character of pain: Dull Sharp Tearing Burning Crampy None Other: _____
Symptoms are: Mild Moderate Severe; Pain score (0-10): At worst _____ and now _____
Pain: Is constant Comes and goes Lasts how long: _____
What makes symptoms better: _____; What makes them worse: _____
Other information about your symptoms: _____
_____

Previous CT, MRI, US, or other tests: _____
_____

Please list all **Medical Problems:**

_____
_____
_____
_____
_____
_____

Please list all **Operations** and dates as best as you can recall:

_____
_____
_____
_____
_____

Please list all **Medications** and doses if you know them:

_____
_____
_____
_____
_____
_____

Allergies: _____

Name: _____ **DOB and age:** _____ **Date:**_____

Please list any **Family Medical History:**

_____

_____

Social History (check, fill in the blanks, or circle):

I am Married Single Divorced Widowed; I live with: _____
Number of children: _____ and ages: _____

I am currently working as a _____ at _____
I used to work as a _____ but _____

[] I am currently smoking _____ packs per day and have been smoking for _____ years.
[] I smoked _____ packs per day for _____ years but quit in _____.
[] I have never smoked.

[] I currently have _____ alcoholic drinks per day and have been drinking for _____ years.
[] I used to drink _____ drinks per day for _____ years but now _____.
[] I have never drunk alcohol.

[] Any recent recreational drug use: _____; or [] None.

Please carefully read this **Review of Symptoms:**

Check "None" or Circle any that apply below:		
GENERAL	[] None	Weight loss or gain, fatigue, fever, night sweats, or change in appetite. How many blocks or flights of stairs you can climb: _____.
INTEGUMENTARY	[] None	Rashes, itching, tattoos, or color change.
HEENT	[] None	Headaches, vision changes, or enlarged nodes or glands.
RESPIRATORY	[] None	Cough, wheezing, shortness of breath, or asthma.
CARDIAC	[] None	Chest pain, heart flutter, or heart murmurs.
GASTROINTESTINAL	[] None	Nausea, vomiting, change in bowel habits, bleeding, constipation, diarrhea, abdominal pain, bloating, hepatitis, light-colored or floating stool, or reflux.
ENDOSCOPY	[] None	Date of last colonoscopy: _____. Last upper endoscopy: _____.
GENITOURINARY	[] None	Painful, difficult, frequent urination, incontinence, or dark urine.
RENAL	[] None	Kidney stones or other problems.
ENDOCRINE	[] None	Thyroid problems or diabetes.
MUSCULOSKELETAL	[] None	Weakness or joint pains.
NEUROLOGICAL	[] None	Fainting, seizures, stroke, loss of vision, or trouble speaking.
HEMATOLOGIC	[] None	Easy bruising or bleeding, anemia, or blood transfusion.
VASCULAR	[] None	Leg pain when walking, blood clots, stroke.
INFECTIOUS	[] None	Recent infections. I take antibiotics before dental procedures.
BREAST	[] None	Pain, history of lumps, or nipple discharge. Date of last mammogram on _____, or [] None.
GYNECOLOGIC	[] None	Vaginal bleeding or discharge.

Reviewed by physician: _____

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VES-13 Questionnaire

Please complete the following questionnaire, even if the questions don't perfectly apply to your situation. Thanks!

1. Name _____ DOB _____ Age _____

2. In general, compared to other people your age, would you say that your health is:

   ☐ Poor,
   ☐ Fair,
   ☐ Good,
   ☐ Very good, or
   ☐ Excellent

3. How much difficulty, on average, do you have with the following physical activities:

	No Difficulty	A little Difficulty	Some Difficulty	A Lot of Difficulty	Unable to do
a. stooping, crouching or kneeling?	☐	☐	☐	☐	☐
b. lifting, or carrying objects as heavy as 10 pounds?	☐	☐	☐	☐	☐
c. reaching or extending arms above shoulder level?	☐	☐	☐	☐	☐
d. writing, or handling and grasping small objects?	☐	☐	☐	☐	☐
e. walking a quarter of a mile?	☐	☐	☐	☐	☐
f. heavy housework such as scrubbing floors or washing windows?	☐	☐	☐	☐	☐

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4. Because of your health or a physical condition, do you have any difficulty:

a. shopping for personal items (like toilet items or medicines)?

☐ YES → Do you get help with shopping? ☐YES ☐NO
☐ NO
☐ DON'T DO → Is that because of your health? ☐YES ☐NO

b. managing money (like keeping track of expenses or paying bills)?

☐ YES → Do you get help with managing money? ☐YES ☐NO
☐ NO
☐ DON'T DO → Is that because of your health? ☐YES ☐NO

c. walking across the room? USE OF CANE OR WALKER IS OK.

☐ YES → Do you get help with walking? ☐YES ☐NO
☐ NO
☐ DON'T DO → Is that because of your health? ☐YES ☐NO

d. doing light housework (like washing dishes, straightening up, or light cleaning)?

☐ YES → Do you get help with light housework? ☐YES ☐NO
☐ NO
☐ DON'T DO → Is that because of your health? ☐YES ☐NO

e. bathing or showering?

☐ YES → Do you get help with bathing or showering? ☐YES ☐NO
☐ NO
☐ DON'T DO → Is that because of your health? ☐YES ☐NO

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Name _____ DOB _____ Age _____

Please complete the following questionnaire, even if the questions don't perfectly apply to your situation. Thanks!

The G8 Questionnaire	
Items	**Possible Responses** **Please Circle The Best Answer**
Has your food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing, or swallowing difficulties?	0 = Severe decrease in food intake 1 = Moderate decrease in food intake 2 = No decrease in food intake
Have you had weight loss during the last 3 months?	0 = Weight loss >3 kg 1 = Do not know 2 = Weight loss between 1 and 3 kg 3 = No weight loss
How is your mobility?	0 = Bed or chair bound 1 = Able to get out of bed/chair but does not go out 2 = Goes out
Do you have any dementia or depression?	0 = Severe dementia or depression 1 = Mild dementia 2 = No psychological problems
Do you takes more than three prescription drugs per day?	0 = Yes 1 = No
In comparison with other people of the same age, how do you consider your health status?	0.0 = Not as good 0.5 = Does not know 1.0 = As good 2.0 = Better
Age	0 = >85 1 = 80–85 2 = <80
Body mass index (BMI)? (weight in kilograms) / (height in square metres)	0 = BMI <19 1 = BMI 19 to <21 2 = BMI 21 to <23 3 = BMI ≥23

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Name _____ DOB _____ Age _____

Please complete the following questionnaire, even if the questions don't perfectly apply to your situation. Thanks!

In the last week, how often did you feel that:

(a) Everything I did was an effort.

1 None, some or a little of the time (0-2 days)
2 A moderate amount of the time (3-4 days)
3 Most of the time (> 4 days).

(b) I could not get going.

1 None, some or a little of the time (0-2 days)
2 A moderate amount of the time (3-4 days)
3 Most of the time (> 4 days).