Tennessee Valley Gastroenterology, LLC **Date:________________________**

Name: ____ Date of Birth: ___________________

Referring Doctor: _____________ Family Doctor: ______________ Pharmacy: ________________________

Reason for visit: ____

Surgical History: ____

Most recent colonoscopy: _________________ Most recent EGD (upper scope): ______________

Women: Pregnant or Nursing? Y / N Last period: ____________ Latex allergy: Y / N

Drug allergies: ____

Medical History:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clots
- ☐ Bronchitis
- ☐ Cancer – type: _____________
- ☐ Cirrhosis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prostate
- ☐ Seizures
- ☐ Sleep apnea with CPAP
- ☐ Stroke
- ☐ Thyroid
- ☐ TB
- ☐ Ulcers
- ☐ Other: ________________

General:

- ☐ Change in appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Fatigue
- ☐ Headache

ENT:

- ☐ Hearing loss
- ☐ Nosebleeds
- ☐ Dizziness
- ☐ Glaucoma

Respiratory:

- ☐ Cough
- ☐ Shortness of breath/wheezing

Cardiovascular:

- ☐ Chest pain
- ☐ Irregular heartbeat/Heart attack

Gastrointestinal:

- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Colon polyps
- ☐ Colon cancer
- ☐ Heartburn
- ☐ Gallstones

Musculoskeletal:

- ☐ Arthritis
- ☐ Back pain
- ☐ Gout

Neurologic:

- ☐ Fainting
- ☐ Memory loss
- ☐ Stroke
- ☐ Seizure

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Eating disorder
- ☐ Stress

Skin:

- ☐ Itching or rash
- ☐ Jaundice
- ☐ Hair/nail changes

Hematology:

- ☐ Anemia
- ☐ Blood transfusion
- ☐ Issues with bleeding/clotting

Genitourinary:

- ☐ Blood in urine
- ☐ Painful urination
- ☐ Difficulty urinating

Family History (Please check each box that applies):

	Colon Cancer	Liver Cancer	Breast Cancer	Colon Polyps	Pancreatic Cancer	Ovarian Cancer	Crohns/Ulcerative Colitis	Stomach Cancer	Cirrhosis of the liver	Esophageal cancer
Father										
Mother										
Sister										
Brother										

Current Prescription and Over-the-counter Medications:

Social History:

Smoker:

- ☐ Yes
- ☐ No

If yes – When did you start smoking? ______________________________

How often do you smoke? ____________________ How many cigarettes a day? ____________________

How soon after waking up do you smoke your first cigarette? ______________________________

Are you interested in quitting? ______________

Alcohol:

- ☐ Yes
- ☐ No

If yes – How often did you have a drink containing alcohol in the past year? ______________________

How many drinks did you have on a typical day in the past year? ____________

How often did you have 6 or more drinks on one occasion in the last year? ________________

Marijuana Use: (Circle one): Yes / No

NAME: ______________________________

ADDRESS: ______________________________

CITY: ________________ **STATE:** ____________ **ZIP CODE:** ______

PHONE NUMBER: (HOME)_____________ **(CELL)** ___________

DATE OF BIRTH: _______________

SOCIAL SECURITY NUMBER: _________________________

EMAIL ADDRESS: ______________________________

Do you have someone to make medical decisions for you if you are not able to do so?

_____ **YES** _____ **NO**

Authorization to view prescription history from external sources:

You have my permission to view prescription history from external source:

Patient's signature: ______________________________

Tennessee Valley Gastroenterology, L.L.C.

416 N. Seminary Street
Florence, AL 35630-6408
PHONE: (256) 766-8667
FAX: (256) 767-5327

PATIENT'S NAME: ____

DATE OF BIRTH: ____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO: **TENNESSEE VALLEY GASTRONENTEROLOGY**

RECORDS REQUESTED: ____

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:

____ DATE: ________________

WITNESS:

____ DATE: ________________

Tennessee Valley Gastroenterology, L.L.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, ____________________ have received a copy of Tennessee Valley Gastroenterology's Notice of Privacy Practices.

______________________________ ______________________
Signature of Patient Date

WE DO NOT DISCUSS YOUR RECORD WITH YOUR FAMILY MEMBERS UNLESS WE HAVE YOUR PERMISSION. LIST BELOW ANY FAMILY MEMBER OR MEMBERS WITH WHOM WE ARE ALLOWED TO DISCUSS YOUR RECORD

______________________________ ______________________________

______________________________ ______________________________