East Tennessee Colon & Rectal Surgical Associates, P.C.
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CONFIDENTIAL PATIENT INFORMATION

FULL NAME: ____ DATE: _______________

COMPLETE ADDRESS: ____
PHONE: (_____)_________________ AGE: ______ DATE OF BIRTH: ___________ SEX: M F
SOCIAL SECURITY #: __________________________ MARITAL STATUS: M S W D

EMPLOYER: ____________________________________ ADDRESS:______________________
WORK PHONE: __________________ OCCUPATION: ________________________________
IF RETIRED, FORMER OCCUPATION:____
IF DISABLED, FROM WHAT:____

INSURANCE COMPANY: ______________________________ ID #:_______________________
SECONDARY INSURANCE: ____________________________ ID # _______________________

SPOUSE'S NAME: __________________________ SS # __________________ D.O.B.________
SPOUSE'S EMPLOYER: ____
ADDRESS: ____ PHONE: ______________________

NEAREST RELATIVE **NOT** LIVING WITH YOU: _____________________________________
ADDRESS: ____ PHONE: ______________

FAMILY PHYSICIAN: _______________________________ ADDRESS: __________________
WHO REFERRED YOU TO OUR PRACTICE: ____

REASON FOR COMING TO OFFICE TODAY OR COMPLAINTS:

____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (Including dosage & frequency)

	(name) (dosage) (how often)		(name) (dosage) (how often)
1.	_______________________________________	2.	_________________________________
3.	_______________________________________	4.	_________________________________
5.	_______________________________________	6.	_________________________________

LIST ALLERGIES TO MEDICINES:____
ARE YOU ALLERGIC TO LATEX, IODINE OR X-RAY DYE ? Y N
HAVE YOU EVER HAD A COLONOSCOPY ? Y N WHEN WAS MOST RECENT?__________

CIRCLE YES OR NO IF YOU HAVE HAD ANY OF THE FOLLOWING:

Condition			Condition		
High Blood Pressure	Y N	__________________	Diabetes	Y N	_______________________
Heart Trouble	Y N	__________________	Stroke	Y N	_______________________
Bleeding Problems	Y N	__________________	HIV/AIDS	Y N	_______________________
Kidney Disorders	Y N	__________________	Heart Murmur	Y N	_______________________
Colon Disorders	Y N	__________________	Cancer	Y N	_______________________
Other Illnesses	Y N	__________________			

PLEASE LIST PAST SURGERIES, HOSPITALIZATIONS OR INJURIES:

Operations/Illness	Date	Physician/Hospital

CHILDBIRTH INFORMATION:

List dates and types of delivery: (vaginal delivery or c-section) ______________________________

____

FAMILY HISTORY:

Please list any medical problems in your relatives:

Father______________________________ Mother______________________________

Siblings____

Children____

SOCIAL HISTORY:

Tobacco Use ☐ Never ☐ Quit/when_______ ☐ Current / packs per day ____________________

Alcohol Use ☐ Never ☐ Rarely ☐ Moderate ☐ Daily How much? ______________

Drug Use ☐ Never ☐ Past History/ Quit when? Type? ______________ ☐ Current Drug User

How often do you have a bowel movement ? ______________________________

Do you use laxatives ? Y N How often/What kind ? ______________________________

REVIEW OF SYSTEMS: Please circle:

☐ **Constitutional**
- Good General Health Y N
- Recent weight change Y N
- Night sweats, fevers Y N
- Fatigue/Weakness Y N

☐ **ENT**
- Hearing loss or ringing Y N
- Sinus problems Y N
- Nose bleeds Y N
- Sore throat Y N

☐ **Eyes**
- Wear glasses/contacts Y N
- Blurred/Double vision Y N
- Eye disease or injury Y N
- Glaucoma Y N

☐ **Cardiovascular**
- Chest pain Y N
- Palpitations Y N
- Heart trouble Y N
- Swelling hands/feet Y N

☐ **Respiratory**
- Shortness of breath Y N
- Cough Y N
- Wheezing/Asthma Y N
- Coughing up blood Y N

☐ **Musculoskeletal**
- Muscle pain or cramps Y N
- Stiffness/swelling joints Y N
- Joint Pain Y N
- Trouble walking Y N

☐ **Neurological**
- Frequent headache Y N
- Paralysis or tremors Y N
- Convulsions/seizures Y N
- Numbness/tingling Y N

☐ **Integumentary (Skin/Breast)**
- Change in hair or nails Y N
- Rashes or itching Y N
- Breast lump Y N
- Breast pain/discharge Y N

☐ **Endocrine**
- Excessive thirst/urination Y N
- Thyroid disease Y N
- Hormone problem Y N

☐ **Hematologic/Lymphatic**
- Bruise easily Y N
- Slow to heal Y N
- Enlarged glands Y N

☐ **Psychiatric**
- Insomnia Y N
- Confusion/memory loss Y N
- Depression Y N

☐ **Genitourinary**
- Blood in Urine Y N
- Kidney stones Y N
- Testicle pain Y N
- Menstrual pain Y N

☐ **Gastrointestinal**

Nausea/vomiting	Y N	How long? ______________
Abdominal Pain	Y N	How long? ______________
Pain w/ bowel movement	Y N	How long? ______________
Unable to control gas	Y N	How long? ______________
Unable to control BM	Y N	How long? ______________
Constipation/diarrhea	Y N	How long? ______________
Diarrhea	Y N	How long? ______________
Awakened by rectal pain	Y N	How long? ______________
Rectal burning	Y N	How long? ______________
Rectal bleeding	Y N	How long? ______________

- **To the best of my knowledge, this information is correct and accurate. I authorize the release of medical information necessary to process my insurance claims. I authorize payment of insurance benefits to the Physician.**

SIGNED X____________________

I have reviewed with patient:

__________MD