PATIENT REGISTRATION FORM

Date: ________________

Primary Care Physician: ______________________________ Phone: (____)__________

Referring Doctor: __________________________________ Phone: (____)__________

Social Security #: _________ - _________ - _____________

Name: ____ DOB: __________________

Address: ____ APT: __________________

City: _____________________ State: _______ Zip: ________ County: ________________

Home Phone: (_____) ______ - ______________ Cell Phone: (_____) ______ - ____________

E-Mail Address: _______________________________________@ ____________________

Marital Status: Circle One: **MARRIED / SINGLE / DIVORCED / PARTNER / WIDOWED**

EMPLOYMENT INFORMATION:

Employer: ___________________________________ Work # (______) ______ - _________

FULL TIME / PART TIME / SELF EMPLOYED / ACTIVE MILITARY / RETIRED

GUARANTOR INFORMATION: *(person who carries the insurance)*

Name: _______________________________ Social Security #: ___________________

Employer's Name: ______________________ Date of Birth: ______________________

Contact Phone #: (_____)_______ - __________ Relationship to patient: ______________

RACE: White – Caucasian / Black-African America / Hispanic / Other: ________________

ETHINICITY: Not Hispanic-Latino / Hispanic-Latino / Patient refuses to provide information

PREFERRED LANGUAGE: English / Spanish / Other: ______________________________

EMERGENCY CONTACT:

Name: ___________________________________ Phone: (_____) ______ - __________

Relationship: ______________________________

PHARMACY INFORMATION:

Name: ___________________________________ Phone: (_____) ______ - ___________

Address: ____

NASHVILLE GASTROINTESTINAL SPECIALISTS, INC. – H&P Date:___________

PATIENT NAME: ___________________________________ *(Last)* *(First)* **Patient's Best Contact Phone:** (_____) _________________	**DOB:** _____________ **AGE:** _____________ **WEIGHT:** __________ **HEIGHT:** __________
PCP ***(primary care Dr)*** ___________________________________ **Referring Dr** *(if different than PCP)* _________________________	**Phone:** (____)___________ **Phone:** (____)___________

GENERAL / CONSTITUTIONAL	YES	NO	GASTROINTESTINAL	YES	NO	MUSCULOSKELETAL	YES	NO
Fatigue			Abdominal swelling			Gout		
Fever			Anal or rectal pain			Arthritis		
Loss of Appetite			Abdominal pain			Back Pain		
Weight Gain			Change in bowel habits			Muscle Weakness		
Weight Loss			Constipation			**DERMATOLOGIC**	**YES**	**NO**
OPTHALMOLOGIC	**YES**	**NO**	Diarrhea			Allergies		
Glaucoma			Dysphagia (trouble swallowing)			Hives		
HEENT / NECK	**YES**	**NO**	Gassy			Itching		
Loss of Vision			Heartburn			Jaundice *(yellowing of skin)*		
Sinus Problems			Incontinence of stool			Rash		
ENDOCRINE	**YES**	**NO**	Nausea			**NEUROLOGIC**	**YES**	**NO**
Diabetes			Rectal bleeding			Headache		
Thyroid Disorder			Vomiting			Seizures		
RESPIRATORY	**YES**	**NO**	HEMATOLOGY	**YES**	**NO**	Tremor		
Asthma			Blood Disorder			Vertigo		
Cough			Blood Transfusion			**PSYCHIATRIC**	**YES**	**NO**
DOE *(dyspnea on exertion)*			Anemia			Anxiety		
Trouble Breathing			Easy / Prolonged bleeding			Depression		
CARDIOVASCULAR	**YES**	**NO**	Enlarged lymph nodes			Sleep Disturbances		
Syncope			**GENITOURINARY**	**YES**	**NO**	Any other Psychiatric Disorder		
Chest Pain			Dark urine					
Irregular heart beat			Decrease in urine flow					
Palpitations			Recurrent Urinary Tract Infections					
Swelling of ankles			Blood in urine					
			Urinary frequency					

PREVIOUS SURGERIES -- Please list all previous surgeries.

1.	4.	7.
2.	5.	8.
3.	6.	9.

PAST / PRESENT MEDICAL CONDITIONS -- Please mark all that apply: _____ ***No Medical Condition***

___ Cancer ___ Depression ___ Heart Disease ___ IBS

___ Congestive Heart Failure ___ Diabetes ___ Hepatitis C ___ Low Thyroid

___ Coronary Artery Disease ___ Diverticulosis ___ High Blood Pressure ___ Obesity

___ COPD ___ GERD / Reflux ___ High Cholesterol ___ Ulcerative Colitis

___ Crohn's Disease ___ Glaucoma ___ High Thyroid

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU MAY HAVE:

____

____

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SOCIAL HISTORY

Do you drink alcohol? **YES / NO** IF yes, what kind ? **BEER / WINE / HARD LIQOUR**

How much: ________________________ *How often:* ______________________

Do you currently smoke? **YES / NO** Amount per day: __________ How Long? __________

Have you smoked in the past? **YES / NO** Amount per day: __________ How Long? __________

Do you do recreational drugs? **YES / NO** If yes, what type: ______________________________

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Please circle family members with any of the following medical history….

Colon Cancer	Mother	Father	Sister	Brother	Daughter	Son
Biliary Cancer	Mother	Father	Sister	Brother	Daughter	Son
Pancreatic Cancer	Mother	Father	Sister	Brother	Daughter	Son
Other Cancer	Mother	Father	Sister	Brother	Daughter	Son

Type of Cancer ____

Colon Polyps	Mother	Father	Sister	Brother	Daughter	Son
Crohn's Disease	Mother	Father	Sister	Brother	Daughter	Son
Diabetes	Mother	Father	Sister	Brother	Daughter	Son
Heart Disease	Mother	Father	Sister	Brother	Daughter	Son
Hypertension	Mother	Father	Sister	Brother	Daughter	Son
Liver Disease	Mother	Father	Sister	Brother	Daughter	Son
Spastic Colon	Mother	Father	Sister	Brother	Daughter	Son
Stroke	Mother	Father	Sister	Brother	Daughter	Son
Ulcers	Mother	Father	Sister	Brother	Daughter	Son
Ulcerative Colitis	Mother	Father	Sister	Brother	Daughter	Son

ALLERGY & MEDICATION LIST

TODAY'S DATE: _____________

PATIENT NAME: ___________________________ DATE OF BIRTH: ____________

ALLERGIES:

_____ NO KNOWN DRUG ALLERGIES   _____ NO KNOWN FOOD ALLERGIES

_____ Barbiturates   _____ Benzodiazepines   _____ Codeine Sulfate
_____ Penicillins   _____ Sulfa (Sulfonamide Antibiotics)

Please list **ANY** additional ALLERGIES you may have below.

Please list **ANY** medication that you take on a regular basis

NAME OF MEDICATION	STRENGTH / MG	DOSAGE (how many per day)