FAMILY PHYSICIANS OF GREENEVILLE
1410 Tusculum Blvd. Ste. 2600 Greeneville, TN 37745
(423)787-7000

Medical History Questionnaire

Welcome! Please take a few minutes to carefully answer the questions below.

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

How did you hear about our office?
Google [ ] Facebook [ ] Friend/Family [ ] Other_____

CURRENT MEDICAL PROBLEM

Please list and describe the problems you need to see the doctor for.

_____

_____

_____

PAST MEDICAL HISTORY

(PLEASE CHECK ALL THAT REPLY)

___ Allergies (seasonal)
___ Alzheimer's disease / dementia
___ Anemia, type _____
___ Anxiety
___ Arthritis, type_____
___ Asthma
___ Arrhythmia
___ Attention Deficit Disorder (ADD)
___ B12 deficiency
___ Bipolar disease
___ Blood clot, site _____
___ BPH (enlarged prostate)
___ Bronchitis (chronic)
___ Cancer, type _____
___ Colitis or Crohn's Disease
___ Congestive heart failure (CHF)
___ Constipation (chronic)
___ COPD (emphysema) Do you use O2? [ ]Y [ ] N
___ Depression
___ Diabetes
___ Epilepsy (seizure disorder)
___ Fibromyalgia
___ GERD (heartburn)
___ Gout
___ Headaches (chronic), type _____
___ Heart attack, year _____
___ Heart disease
___ Heart murmur
___ Heart palpitations (racing heart)
___ High blood pressure
___ High cholesterol
___ Irritable bowel syndrome (IBS)
___ Kidney problems _____
___ Kidney stones
___ Liver disease/chronic hepatitis, type _____
___ Lupus (SLE)
___ Mental retardation
___ Obesity
___ Osteoporosis
___ Pain, chronic [ ] Back [ ] Neck [ ] Leg
___ [ ] Other _____
___ Restless leg syndrome
___ Sexually transmitted disease, type _____
___ Sleep apnea Do you use CPAP? [ ] Yes [ ] No
___ Sleep problems
___ Stroke
___ Suicide attempt
___ Ulcers
___ UTI (urinary tract infections (chronic))
___ Urinary incontinence
___ Vertigo
Other conditions not listed: _____

_____

_____

_____

_____

_____

- Surgical Procedures: Please list all previous surgical procedures (approximate dates)

Year	Surgical Procedure & physician providing care	Location of Hospital

- Please List All Hospitalizations (for reasons other than surgery)

Illness / Problem	Medical Facility / Hospital	Doctor	City

- Who was your most recent primary care doctor? _____

  Phone number: _____ Last date seen: _____

- List of other medical providers who treat you:

Name	Specialty	Phone/Fax

- **Medications** (Please list **ALL** meds you are taking **including over the counter & herbal medications**)
  All medications MUST be brought in with you to your first appointment

Medication Name (Example: Aspirin)	Dosage/Strength (Example: 81 mg)	Directions (Example: once a day in the evening)

- What pharmacy do you use? _____

- For Women Only:
  How many times have you been pregnant? _____
  How many times have you given birth? _____
  Any miscarriages or abortions? _____
  Do you have regular monthly periods? YES [ ] NO [ ] - Age at menopause _____

- Do you have a living will, power of attorney, or advance directives? Yes [ ] No [ ]
  If yes, please bring a copy to your first appointment.

ALLERGIES AND SENSITIVITIES

- Please list all medicines you are allergic to and describe how each one affects you

Name of Medicine(s) You Are Allergic To	Reaction

- Please list any food, dust, chemical, soap, pollen, household item, bee sting, etc that you are allergic to and describe how each one affects you (including eggs or egg products)

FAMILY HEALTH AND HISTORY

- Please select the appropriate boxes

Family Member	Heart Disease	Stroke	Cancer	Diabetes	Other Problems	Deceased	Age (at death)
Father	[ ]	[ ]	[ ]	[ ]		Y N	
Mother	[ ]	[ ]	[ ]	[ ]		Y N	
Maternal Grandfather	[ ]	[ ]	[ ]	[ ]		Y N	
Maternal Grandmother	[ ]	[ ]	[ ]	[ ]		Y N	
Paternal Grandfather	[ ]	[ ]	[ ]	[ ]		Y N	
Paternal Grandmother	[ ]	[ ]	[ ]	[ ]		Y N	
Brother #1	[ ]	[ ]	[ ]	[ ]		Y N	
Brother #2	[ ]	[ ]	[ ]	[ ]		Y N	
Brother #3	[ ]	[ ]	[ ]	[ ]		Y N	
Sister #1	[ ]	[ ]	[ ]	[ ]		Y N	
Sister #2	[ ]	[ ]	[ ]	[ ]		Y N	
Sister #3	[ ]	[ ]	[ ]	[ ]		Y N	
Son #1	[ ]	[ ]	[ ]	[ ]		Y N	
Son #2	[ ]	[ ]	[ ]	[ ]		Y N	
Son #3	[ ]	[ ]	[ ]	[ ]		Y N	
Daughter #1	[ ]	[ ]	[ ]	[ ]		Y N	
Daughter #2	[ ]	[ ]	[ ]	[ ]		Y N	
Daughter #3	[ ]	[ ]	[ ]	[ ]		Y N	

- Other significant family medical history: _____

_____

SOCIAL HISTORY AND PERSONAL HABITS

- Please list who lives with you at home

  _____

- Please give the name of your spouse (and the year of marriage) or year of recent divorce

  _____

- Please list your occupation: _____

- Birth Place: _____ Family Home: _____

- Substance Use

  Are you currently a smoker? NO [ ] YES [ ] Cigarettes, Cigars, Pipe
  Have you smoked in the past? NO [ ] YES [ ] If so, for how long?_____
  Do you chew tobacco or dip snuff? NO [ ] YES [ ] If so, for how long?_____
  Do you use alcohol-containing beverages? NO [ ] YES [ ]
  If yes, circle the type – Beer, Wine, Distilled Liquor
  and how often – Daily, Weekly, Monthly, Yearly, Very Rarely

- Education: How far did you go in school? _____

- Do you exercise? If yes, how? _____ How often? _____

- What do you do for fun? _____

- Have you recently had any changes in any of the following? If yes, please explain

  Marital status? NO [ ] YES [ ] _____
  Job or work? NO [ ] YES [ ] _____
  Residence? NO [ ] YES [ ] _____
  Financial status? NO [ ] YES [ ] _____

- Have you recently felt unsafe or endangered in your home? YES [ ] or NO [ ]

If yes, please explain? _____

HEALTH PRESERVATION

- When was your last complete physical exam? _____

- When was your last eye exam? _____ Who was it with? _____

- When was your dental exam? _____ Who was it with? _____

- Have you had a tetanus booster in the last 10 years? YES [ ] NO [ ] If so, when? _____

- Have you ever had a colonoscopy? YES [ ] NO [ ] Date _____ By Dr. _____

- Women, when was your last pap smear: _____ Mammogram _____

Thank you for completing this questionnaire. Your doctor will review this information carefully.

FAMILY PHYSICIANS OF GREENEVILLE, PC
PATIENT REGISTRATION FORM DATE: _____

PATIENT'S LAST NAME	FIRST	MI	SEX	BIRTHDATE

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY #	HOME PHONE	CELL PHONE	MARITAL STATUS	RACE

EMPLOYER NAME	EMPLOYER ADDRESS

PERSON RESPONSIBLE FOR PAYMENT

LAST NAME	FIRST	MI	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY #	HOME PHONE	CELL PHONE	MARITAL STATUS	RACE

EMPLOYER NAME	EMPLOYER ADDRESS

IN CASE OF EMERGENCY, CONTACT:

NAME	HOME PHONE	WORK PHONE	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE		TERIARY INSURANCE	
INSURANCE NAME		INSURANCE NAME		INSURANCE NAME	
CLAIMS ADDRESS		CLAIMS ADDRESS		CLAIMS ADDRESS	
INSURANCE PHONE NUMBER		INSURANCE PHONE NUMBER		INSURANCE PHONE NUMBER	
ID NUMBER		ID NUMBER		ID NUMBER	
GROUP NUMBER	IS THIS THROUGH AN EMPLOYER? YES [ ] NO [ ]	GROUP NUMBER	IS THIS THROUGH AN EMPLOYER? YES [ ] NO [ ]	GROUP NUMBER	IS THIS THROUGH AN EMPLOYER? YES [ ] NO [ ]
HMO [ ] PPO [ ] POS [ ] OTHER [ ]		HMO [ ] PPO [ ] POS [ ] OTHER [ ]		HMO [ ] PPO [ ] POS [ ] OTHER [ ]	
SUBSCRIBER	SEX	SUBSCRIBER	SEX	SUBSCRIBER	SEX
SUBSCRIBER SOCIAL SECURITY #		SUBSCRIBER SOCIAL SECURITY #		SUBSCRIBER SOCIAL SECURITY #	
SUBSCRIBER'S BIRTHDATE	EFFECTIVE DATE	SUBSCRIBER'S BIRTHDATE	EFFECTIVE DATE	SUBSCRIBER'S BIRTHDATE	EFFECTIVE DATE
PATIENT'S RELATIONSHIP TO PATIENT		PATIENT'S RELATIONSHIP TO PATIENT		PATIENT'S RELATIONSHIP TO PATIENT	

Please present your insurance cards so we can copy them for our files.

The Patient or Guarantor is responsible for payment in full of all services rendered by Family Physicians of Greeneville, P.C. Payment in full is expect the time of service unless arrangements are made in advance.

Authorization for Release of Medical Records
Family Physicians of Greeneville
1410 Tusculum Blvd, Suite 2600, Greeneville, TN 37745
(Voice) 423-787-7000; (Fax) 423-787-7049

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name	Date of Birth	Social Security Number	
Address	City/State	Zip	Phone

RELEASE FROM:			
Physician / Facility		Fax	
Address	City / State	Zip	Phone

RELEASE TO:			
Physician / Facility		Fax	
Address	City / State	Zip	Phone

RELEASE INFORMATION

Reason: [ ] Medical Care [ ] Transfer of care [ ] Personal file
[ ] Moving out of area [ ] Specialist consultation [ ] Legal

Please release the following (check all that apply)

[ ] ALL RECORDS	[ ] LAST _____ YEARS OF RECORDS
[ ] LABS / X-RAYS Dates:_____	[ ] OTHER: _____

CONSENT

I authorize the release of all information indicated (to be sent by fax or mail), including current and previous records from other facilities.
I authorize telephone communication by office staff of the above named facility.
I agree that a copy or fax of this release is a valid as the original.
I understand if the above named recipient is not a health plan or health care provider covered by HIPAA regulation, that the released information may be disclosed by the recipient and may no longer be protected by federal or state privacy laws.
I understand that the released medical records may contain information about:

- Psychological, psychiatric, or other mental impairments (excludes "psychotherapy notes" per 45 CFR 164.501)
- Drug abuse, alcoholism, or other substance abuse
- Sickle cell anemia
- Records which may indicate the presence of communicable or noncommunicable diseases, and tests for or records of HIV/AIDS
- Gene-related impairments (including genetic test results)

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation.
I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of patient or legal guardian	Date
Witnessed by	Date

Note: This consent is valid for 12 months from the date signed, unless revoked prior to that date.

IF YOU HAVE HAD A COLONOSCOPY, PLEASE FILL THIS OUT

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RELEASE FROM:			
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RELEASE TO:			
Physician / Facility		Fax	
Address	City / State	Zip	Phone

RELEASE INFORMATION		
Reason: [ ] Medical Care	[ ] Transfer of care	[ ] Personal file
[ ] Moving out of area	[ ] Specialist consultation	[ ] Legal

Please release the following (check all that apply)

[ ] ALL RECORDS	[ ] LAST _____ YEARS OF RECORDS
[ ] LABS / X-RAYS Dates:_____	[**X**] OTHER: Last colonoscopy result & last office note

CONSENT

I authorize the release of all information indicated (to be sent by fax or mail), including current and previous records from other facilities.
I authorize telephone communication by office staff of the above named facility.
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