UAB MEDICAL WEST

Gastroenterology Health Center, 5000 Medical West Way, Suite 402, Bessemer, AL 35022 (205) 481-7384

Name _____ Today's Date _____

Social Security No. _____ Date of Birth _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced Gender ☐ Male ☐ Female

Home Address _____
Street City State Zip

Phone Numbers: Home _____ Cell _____ Work _____

EmailAddress _____ Preferred Contact Method Phone Mail Email

EMPLOYMENT

Employer _____ Dept./Title _____

Employer's Address _____
Street City State Zip

Employer's Phone _____

EMERGENCY CONTACTS

Spouse/Companion/Guardian:

Name & Relationship _____ Phone _____

Address _____
Street City State Zip

Nearest relative or friend not living with you:

Name & Relationship _____ Phone _____

Address _____
Street City State Zip

Health History Questionnaire **All questions contained in this questionnaire are strictly confidential and will become part of your medical record.**				
Employment	☐ Full Time ☐ Part Time ☐ Homemaker ☐ Retired ☐ Disabled ☐ Student ☐ Other			
	Current Occupation:			
	Past Occupation:			
Personal Safety	Do you live alone? ☐ Yes ☐ No If no? ☐ With Family ☐ With Spouse ☐ Other			
	Do you have frequent falls?			☐ Yes ☐ No
	Do you have vision or hearing loss?			☐ Yes ☐ No
	Do you have an Advance Directive and /or a Living Will?			☐ Yes ☐ No
	Would you like information on Advance Directives?			☐ Yes ☐ No
Exercise	☐ No exercise			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x weekly for 30 minutes)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x weekly for 30 minutes)			
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	How many drinks per day?			
Tobacco	Do you use tobacco			☐ Yes ☐ No
	☐ Cigarettes pkg/day_____	☐ Chew #/day _____	☐ Pipe #/day _____	☐ Cigars #/day
	_____# of years	☐ Previous user	_____ # of years quit	
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No
	What kind?			

UAB MEDICAL WEST

Gastroenterology Health Center, 5000 Medical West Way, Suite 402, Bessemer, AL 35022 (205) 481-7384

Name_____ **Date of Birth**_____

ALLERGIES

Medication Name	Type of Reaction	Comments

MEDICATIONS - Please list all current prescription and non-prescription medications, vitamins and supplements.

Medication Name	Strength	Frequency Taken

Pharmacy Information		
Pharmacy Name:	**Pharmacy Location:**	**Pharmacy Phone #:**
Primary Care Physician	**Practice Name:**	**Physician Phone #**

FAMILY HISTORY

	Living	Deceased	Colon polyps	Colon cancer	Liver disease	Pancreas disease	Crohn's disease	Ulcerative colitis	Stomach cancer
Mother									
Father									
Sister									
Brother									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Other									

UAB MEDICAL WEST

Gastroenterology Health Center, 5000 Medical West Way, Suite 402, Bessemer, AL 35022 (205) 481-7384

Name_____ **Date of Birth**_____

PAST MEDICAL HISTORY

☐ Acid reflux	☐ Chronic sinusitis	☐ Groin hernia	☐ Kidney stones	☐ Polio
☐ Anal fissure	☐ Cirrhosis of liver	☐ Heart attack	☐ Lupus / Scleroderma	☐ Psoriasis
☐ Anemia	☐ Colon cancer	☐ Heart failure	☐ Migraines	☐ Radiation therapy
☐ Arthritis	☐ Colon polyps	☐ Heart murmur	☐ Milk intolerance	☐ Rheumatic fever
☐ Artificial heart valve	☐ Crohn's disease	☐ Hepatitis	☐ Mitral valve prolapse	☐ Sciatica
☐ Asthma	☐ Depression	☐ Hiatal hernia	☐ Multiple sclerosis	☐ Seizures
☐ Bleeding disorder	☐ Diabetes	☐ High blood pressure	☐ Osteoporosis	☐ Sleep apnea
☐ Blood clots	☐ Diverticulitis	☐ High cholesterol	☐ Ovarian cyst	☐ Stomach ulcer
☐ Blood transfusion	☐ Duodenal ulcer	☐ High triglycerides	☐ Pacemaker	☐ Stroke or paralysis
☐ Cancer_____	☐ Emphysema	☐ HIV or AIDS	☐ Pancreatitis	☐ Tuberculosis (TB)
☐ Chest pain / angina	☐ Fatty liver	☐ Irregular heart beat	☐ Parkinson's disease	☐ TB skin test positive
☐ Chronic anxiety	☐ Gallstones	☐ Irritable bowel syndrome	☐ Peptic ulcer	☐ Thyroid disease
☐ Chronic lung disease	☐ Glaucoma	☐ Kidney disease / failure	☐ Phlebitis	☐ Ulcerative colitis
☐ Chronic lung disease	☐ Gout	☐ Kidney infection	☐ Pneumonia	

Any MEDICAL PROBLEMS not listed above:

SURGERIES / PROCEDURES

☐ NONE	☐ Colostomy	☐ Groin hernia	☐ Hiatal hernia repair	☐ Obesity surgery	☐ Thyroid
☐ Appendectomy	☐ C-section	☐ Heart bypass	☐ Hysterectomy	☐ Ovary	☐ Tonsillectomy
☐ Breast	☐ EGD	☐ Heart stent	☐ Joint replacement	☐ Prostate	☐ Tubal ligation
☐ Colon surgery	☐ ERCP	☐ Heart valve	☐ Kidney	☐ Sigmoidoscopy	☐ Uterus
☐ Colonoscopy	☐ Gallbladder	☐ Hemorrhoid surgery	☐ Liver biopsy	☐ Stomach	☐ OTHER

Any SURGERIES not listed above:

UAB MEDICAL WEST

Gastroenterology Health Center, 5000 Medical West Way, Suite 402, Bessemer, AL 35022 (205) 481-7384

Name_____ **Date of Birth**_____

Referred by: _____ **Primary Care Physician:** _____

Other Physicians involved in your healthcare: _____

Describe the reason(s) for your visit: _____

_____

Review of Systems

General	☐ black stools	☐ hemorrhoids
☐ fever or chills	☐ blood in stool	☐ jaundice /yellowing of the skin
☐ loss of appetite	☐ change in bowel habits	☐ mucus in stool
☐ unintentional weight gain	☐ constipation	☐ nausea or vomiting
☐ unintentional weight loss	☐ diarrhea	☐ pain with swallowing
☐ weakness, fatigue	☐ difficulty swallowing	☐ poor appetite
	☐ fat intolerance	☐ rectal bleeding
Gastrointestinal	☐ full after eating small amounts	☐ rectal pain or itching
☐ abdominal distention	☐ gas / bloating	☐ regurgitation of food
☐ abdominal pain/cramping	☐ heartburn	☐ soiling / bowel incontinence
☐ belching	☐ indigestion	☐ vomiting blood

Marijuana/THC/Cannabinoids?

☐ Yes
☐ No

UAB MEDICAL WEST

Gastroenterology Health Center, 5000 Medical West Way, Suite 402, Bessemer, AL 35022 (205) 481-7384

NO SHOW/CANCELLATION ACKNOWLEDGEMENT
APPLICABLE AT ALL MEDICAL WEST HEALTH CENTERS

Printed Name of Patient _____ Date of Birth _____

I acknowledge the following:

- It is important to my health that I show up on time for my doctor's appointment.
- If I do not show up for a scheduled appointment, it may affect my health and it creates an unused appointment slot that could have been used for another patient.
- It is important that I notify my doctor's office at least 24 hours in advance when I need to cancel an appointment.
- My doctor may choose to terminate me from this practice if I have more than two no-show occurrences at any given time.

Printed Name of Patient or Authorized Representative _____

Relationship _____ Patient Signature or Authorized Representative _____ Date/Time _____

UAB MEDICAL WEST

Gastroenterology Health Center, 5000 Medical West Way, Suite 402, Bessemer, AL 35022 (205) 481-7384

RECEIPT FOR HIPAA PRIVACY NOTICE AND AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION (MW119)

Patient Name _____ Date of Birth _____

Social Security Number _____ Preferred Phone Number _____

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that **I may revoke this authorization at any time by notifying Medical West** in writing, but if I do it will not have an effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise. I hereby authorize Medical West to disclose health information to the following:

Name & Relation _____ Phone # _____

Name & Relation _____ Phone # _____

Name & Relation _____ Phone # _____

Name & Relation _____ Phone # _____

PLEASE NOTE THAT NOT ANSWERING THE QUESTIONS BELOW MAY RESULT IN THE STAFF OF MEDICAL WEST LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE.

☐ Yes ☐ No The physicians and staff of Medical West may confirm my appointment to my voice mail / answering machine at the number provided on my patient information sheet.

☐ Yes ☐ No The physicians and staff of Medical West may leave lab results or results of other diagnostic studies (e.g., MRI, CT, Bone Scan, etc.) on my voice mail / answering machine.

☐ Yes ☐ No The physicians and staff may release information to my pharmacy without prior authorization in order to allow call in of a prescription.

Special Instructions _____

My signature below is acknowledgement that I have received a copy of the Medical West Privacy Notice (MR119) and that I agree to the conditions stated in this notice.

Printed Name of Patient or Authorized Representative _____

Relationship _____ Patient Signature or Authorized Representative _____ Date/Time _____