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The state-of-the-art procedure center supporting several regional clinics.

The Center for Digestive Wellness | 10461 Wallace Alley Dr. | Kingsport TN 37663 | ph 423.279.1400 | fx 423.279.1410

Appointment Date _____ Arrival Time _____ Provider _____

Your Appointment Location: <i>Maps of our locations are on the back of this page.</i>	Bristol 1 Medical Park Blvd., Suite 305E 423-844-5190	Johnson City 1301 Sunset Drive, Suite 5 423-854-5832	Kingsport / Airport 10461 Wallace Alley Lane 423-279-1400
Elizabethton 922 West G Street 423-542-6055	Marion 1020 Terrace Drive, Suite 200	Mountain City 377 Cold Springs Road 423-727-1931	Kingsport / Indian Path 2205 Pavilion Drive, Suite 101 423-245-3807

IMPORTANT: Please fill out ALL information requested on this form and fax it back to 423-279-1410 or bring it with you the day of your visit. Please arrive on time for your appointment so that we can process your paperwork and prepare your chart.

Name _____ Male Female
(Last) (First) (Middle Name)

Date of Birth _____ Soc. Sec # _____ Single Married Widowed

Address _____
(Street Name) (City) (State) (Zip Code)

Home Phone _____ Cell Phone _____ Alt. Phone _____

Employer _____ Employer Phone # _____

Employer Address _____

Do you have internet access? Yes No Email Address _____

Spouse's Name _____ Date of Birth _____ Soc. Sec. # _____

Spouse's Employer / Address _____

Emergency Contact (Not at your address): Name _____ Phone _____

Family Physician _____ Referring Physician _____

Primary Insurance _____ Policy # _____ Group # _____

Subscriber Name _____ Soc. Sec. # _____ Date of Birth _____

Insurance Filed Through: Self Spouse Parent/Guardian Referral Required? Yes No

Secondary Insurance _____ Policy # _____ Group # _____

Subscriber Name _____ Soc. Sec. # _____ Date of Birth _____

Insurance Filed Through: Self Spouse Parent/Guardian Referral Required? Yes No

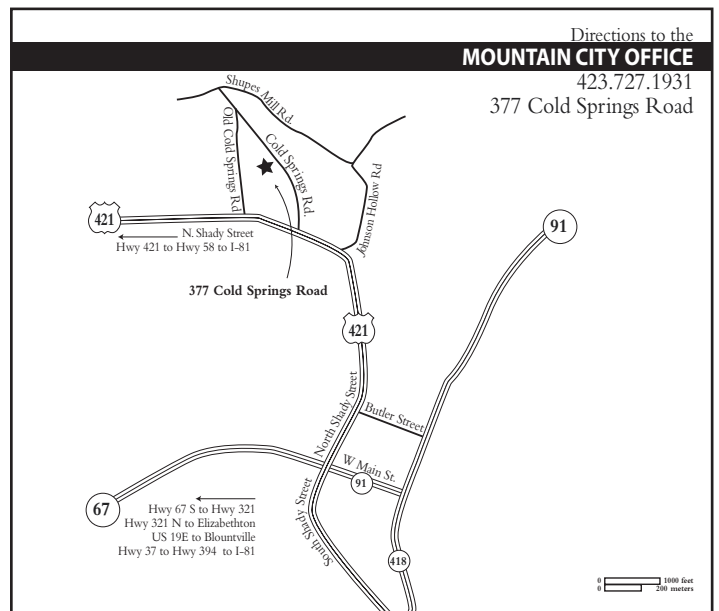
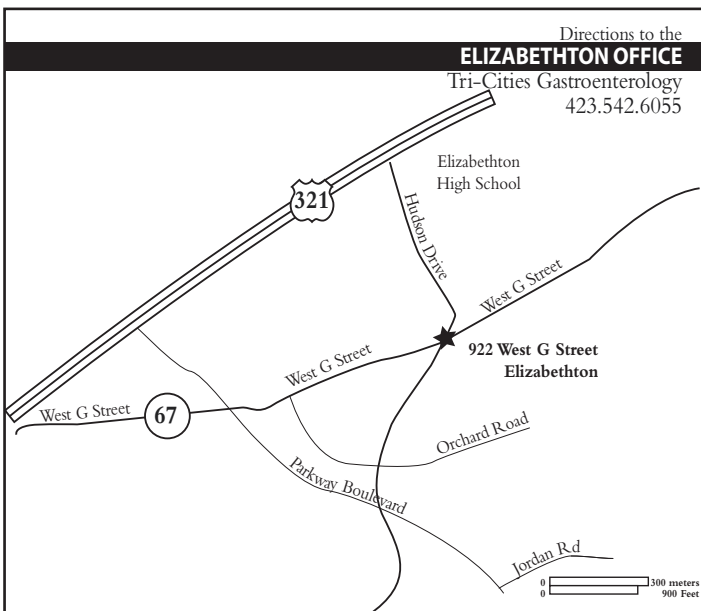
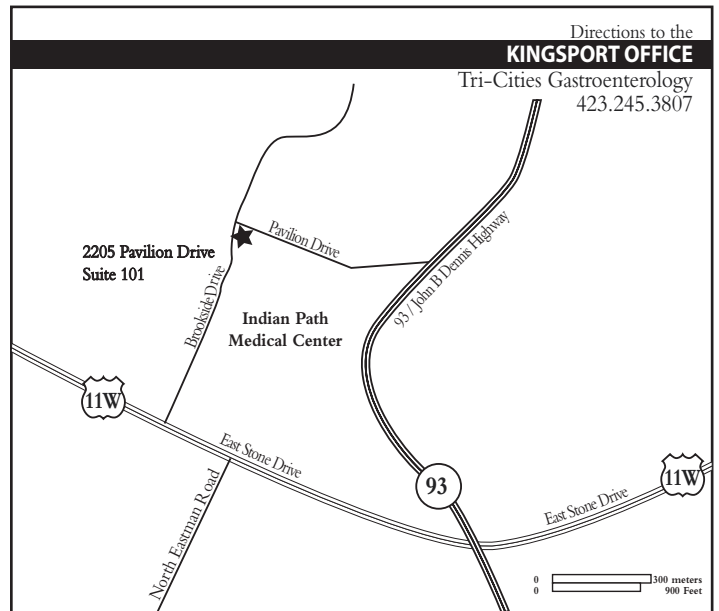
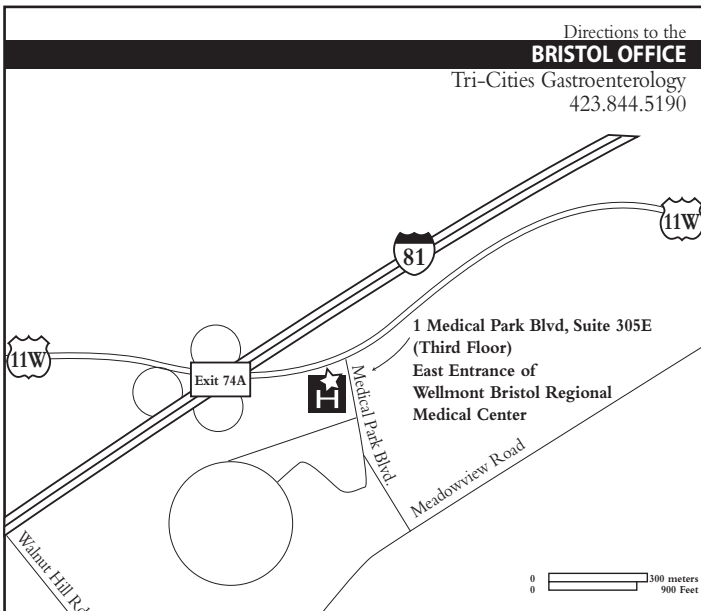
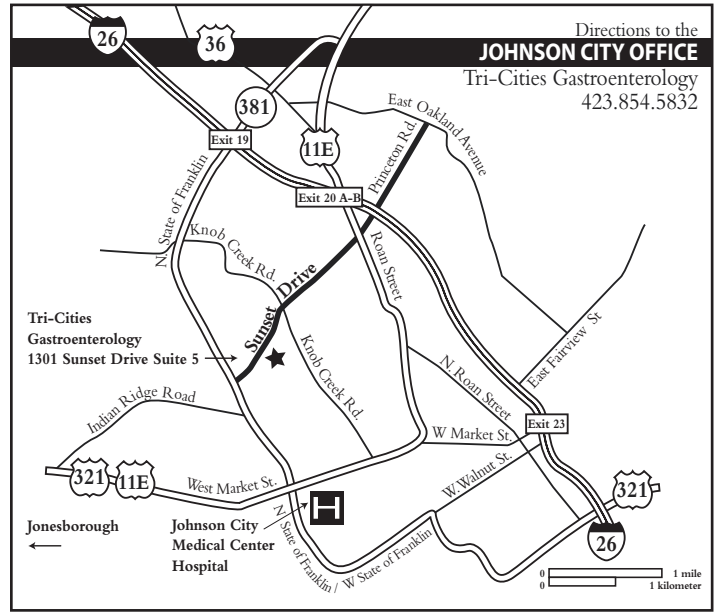
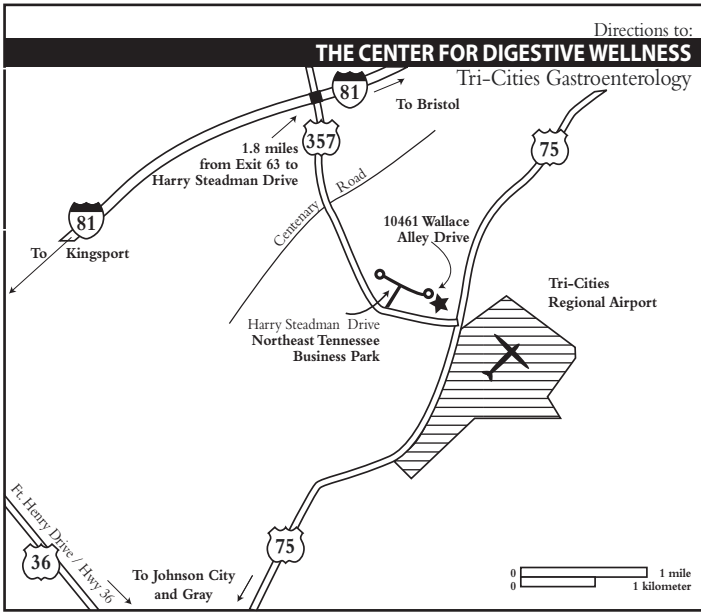
Pharmacy Name _____ Phone _____

****Copays are due at time of service. If your insurance company requires a referral from your primary care doctor, please make sure this is obtained before your visit. If you do not have one, you will be responsible for all charges.**

Providing you with the quality care we expect for our own family.

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The Center for Digestive Wellness / Tri-Cities Gastroenterology: Services Provided at Several Area Locations



Medical Conditions

Please list any medical conditions for which you have been diagnosed (such as high blood pressure, heart attacks, strokes, high cholesterol, etc.)

- 1. _____ 6. _____
- 2. _____ 7. _____
- 3. _____ 8. _____
- 4. _____ 9. _____
- 5. _____ 10. _____

Please list your surgeries, surgeon, and year performed:

- 1. _____ 6. _____
- 2. _____ 7. _____
- 3. _____ 8. _____
- 4. _____ 9. _____
- 5. _____ 10. _____

Personal History

Do you smoke? Yes No How much do you smoke? _____ (packs/day) For how long? _____

Have you ever smoked? Yes No If yes, date quit _____ Number of years smoked _____

Do you use smokeless tobacco / Skoal / snuff? Yes No If yes, how much per day? _____

Do you drink alcohol? Yes No If yes, how much? _____

How frequently do you drink alcohol: _____ When was your last drink: _____

Are you now using or have you *ever* used recreational/illicit drugs: Yes No _____

Family History

Do you have any family history of any of the following? If so please list their relationship to you: _____

✓	Disease	Relationship / Age at Diagnosis	✓	Disease	Relationship / Age at Diagnosis
	Colon Cancer			Colon Polyps	
	Stomach Cancer			Liver Disease	
	Crohn's / Colitis			Gall Bladder Disease	

Are you experiencing any of the following?

Diarrhea Yes No Average number of bowel movements daily _____

Constipation Yes No How many days have you gone without a bowel movement? _____

Bright red rectal bleeding: Yes No Change in your bowel habits: Yes No

Unintentional weight loss: Yes No _____ How much _____ Over what period of time _____

Abdominal pain: Yes No Location: _____

Trouble swallowing *solid* food or liquids: Yes No Painful swallowing: Yes No

Nausea or vomiting: Yes No Heartburn: Yes No

Have you ever been diagnosed with one of the following?

<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Hepatitis (A, B, or C)	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Inflammatory Bowel Disease	<input type="checkbox"/> Crohn's or Ulcerative Colitis

Please check all that apply and use space provided below for details.

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Chest pain on exertion	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic cough
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Frequent urinary tract infections
<input type="checkbox"/> Nocturnal urination	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Painful urination
<input type="checkbox"/> Diabetes (insulin / noninsulin)	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> History of seizures
<input type="checkbox"/> Previous stroke	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Chronic neck or back pain	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Easy bleeding or bruising
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Change in your vision
<input type="checkbox"/> Decrease in hearing	<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Dentures or partials

Have you ever had a colonoscopy, flexible sigmoidoscopy, upper endoscopy? Yes No If yes, please list the date and physician who performed the procedure. _____

Have you ever had an upper GI X-ray (drink white dye), CAT scan, MRI, or ultrasound? Yes No If yes, please list the date and physician who performed the procedure _____

Health Care Maintenance

Date of last cholesterol test: _____ Tetanus: _____ Date of last eye exam _____

Females only:

Last menstrual period _____ Last Pap Smear _____ Last mammogram _____

Have you had a bone density test? Yes No If yes, please give date _____

Total number of pregnancies: _____ Deliveries (vaginal deliveries or C-Section) _____

Abortions: _____ Miscarriages: _____

Males only:

Date of last prostate exam: _____ Date of last PSA: _____

Person completing this form _____ Date _____

Relationship to patient _____ Date _____

Reviewed by _____ Date _____