

**Franklin Gastroenterology, PLLC**  
**Wilmot C. Burch, Jr., MD**  
**Rachel Wagner, APRN**  
**Laura Stone, APRN**  
**740 Cool Springs Blvd., Suite 210**  
**Franklin, TN 37067**  
**615-771-8786**

We would like to welcome you to Franklin Gastroenterology!

Your appointment date and time is:

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Please arrive **30 MINUTES** before your appointment time to allow time to finish the appropriate paperwork and to create a chart for your visit. Please bring your insurance card, picture ID, as well as, your medication list. This visit is a consultation or initial exam, as a rule there are no procedures done the first visit. **If your insurance requires that you have a referral prior to seeing a specialist, you will need to call your primary care physician to have that referral sent to us. We will need to have this referral prior to your scheduled appointment.**

Please be advised, depending on your insurance plan, a copay will be collected at the time of service. If your insurance plan requires a referral you will need to verify with your Primary Care Physician that it has in fact been submitted and that a copy has been sent to our office prior to your scheduled appointment. For any NEW self-pay patients, there is a minimum of **\$150.00**, which will be collected at the time of service. We will apply a self-pay discount to that visit and if there is a remaining balance we will issue a statement. For any ESTABLISHED self-pay patients, there is a minimum of **\$75.00**, which will be collected at the time of service. Again, a self-pay discount will be applied to the visit and if there is a remaining balance you will be issued a statement.

Please complete these forms in their entirety, as we will collect them from you at the time of service. We also have a patient portal that you are invited to use. If you would like access to this prior to your appointment, please call our office and provide a valid email address. Portal access can be found on our website [franklingastroenterology.com](http://franklingastroenterology.com).

We will make every attempt to see you on time, acknowledging the fact that emergent visits do occur.

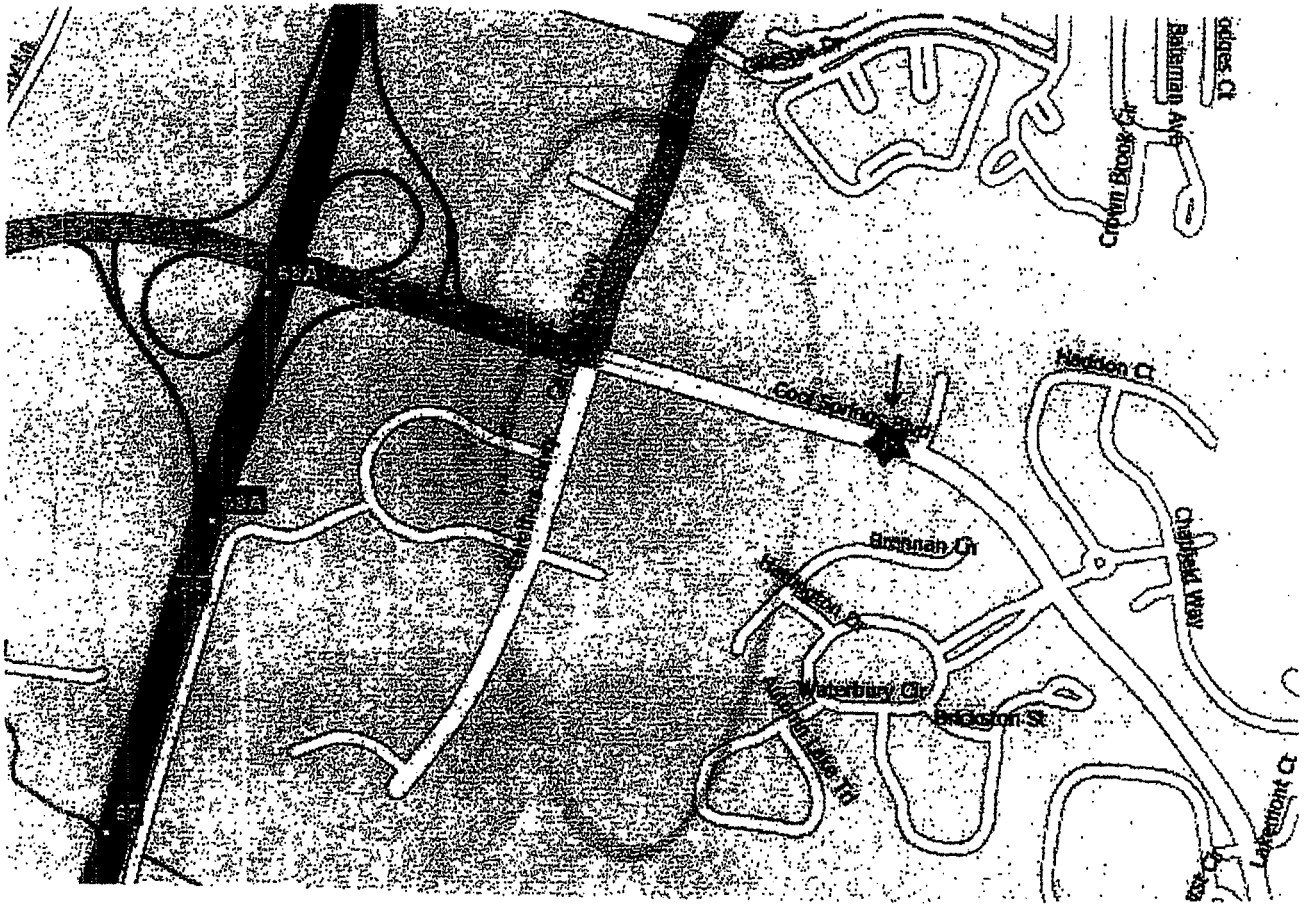
Franklin Gastroenterology does respect your time. Please respect ours as well. If you are unable to make your appointment please call our office at least 24 hours in advance as there are other people who would be able to use that time. Failure to contact the office within a timely manner will result in a \$50.00 No Show Fee for new patients and a \$25.00 No Show Fee for established patients.

Thank you and we look forward to participating in your medical care.

Sincerely,

Franklin Gastroenterology

**FRANKLIN GASTROENTEROLOGY; PLLC**  
**740 COOL SPRINGS BLVD. STE 210**  
**FRANKLIN, TN. 37067**  
**PHONE: 1-615-771-8786**  
**FAX: 1-615-771-2801**



**We are conveniently located off I-65 at exit 68A. Travel Eastbound on Cool Springs Blvd. crossing Carothers Pkwy. Physicians Plaza of Cool Springs is a two story brick Building on the left. Turn left onto Billingsly Ct. and left again into our parking lot. Our office is located on the second floor; Suite 210.**

**Note: This facility is the last commercial Building on the left.**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City, State & Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Contact preference:  Home  Cell  Work

Email: \_\_\_\_\_ SSN #: \_\_\_\_\_ DOB: \_\_\_\_\_

Pharmacy Name & Address: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Employer Name: \_\_\_\_\_  Retired  FT Student  PT Student

Referring Physician: \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Emergency contact phone number: \_\_\_\_\_

**BILLING AND INSURANCE INFORMATION**

Guarantor (person responsible for bills): \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to insured: Self Child Spouse

Subscriber Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Is policy holder spouse? \_\_\_\_\_ Yes \_\_\_\_\_ No Date of birth: \_\_\_\_\_

**PLEASE INITIAL THE FOLLOWING:**

\_\_\_\_\_ I hereby authorize Wilmot C. Burch, MD & Rachel Wagner, APN and/or Franklin Surgery Center to furnish my insurance company any/all information which said insurance company(s) may request.

\_\_\_\_\_ I hereby assign Wilmot C. Burch, MD & Rachel Wagner, APN and/or Franklin Surgery Center all money to which I am entitled for Medical and or Surgical expenses relative to the service rendered. I understand that I am financially responsible to Wilmot C. Burch, MD & Rachel Wagner, APN and/or Franklin Surgery Center for charges NOT covered by this assignment, meaning services NOT covered by my insurance company.

\_\_\_\_\_ I understand that if I cannot pay my balance in full, I can set up a payment plan or apply for Care Credit.

**DELINQUENT ACCOUNTS:** We review past due accounts at every statement cycle. Your communication and involvement to ensure your balance is paid in a timely fashion is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty(60) days past due, further steps to collect this debt may be taken . If you fail to pay on time we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny non-emergency treatment for any and all debtor-related unpaid account balances.

**CONSENT TO CONTACT:** I grant permission and consent to Premier Radiology and its agents, assignees, and contractors(which may include third party debt collectors for past due obligations)(1) to contact me by phone or at any number associated with me, if provided by me or another person on my behalf;(2) to leave messages for me and include in any such messages amounts owed me;(3) to send me text messages or emails using any email I provided or any phone number associated with me, if provided by me or another person on my behalf; and(4)to use prerecorded/artificial voice messages and/or an automated telephone dialing system(auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consumer described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services. **PATIENT SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

# Release Of Medical Information

NAME (Please print): \_\_\_\_\_ DOB: \_\_\_\_\_

By Signing Below, I Authorize AdvancedHEALTH To Release My Medical And Billing Information To:

## RELATIONSHIP

## NAME OF DESIGNATED PERSON

SPOUSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CHILDREN	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
IN-LAWS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVERS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
PARENTS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
OTHERS	_____		

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**We ask that if you have any change in this request, that you please inform the receptionist.**

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AdvancedHEALTH may leave appointment information on my voicemail:

HOME	<input type="checkbox"/> YES	<input type="checkbox"/> NO
WORK	<input type="checkbox"/> YES	<input type="checkbox"/> NO
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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I authorize the following to pick up prescriptions, X-rays, etc.

## RELATIONSHIP

SPOUSE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
RELATIVE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
CAREGIVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**We charge a \$20 flat rate for 1-5 pages plus .50 per additional page and postage.**

I understand that AdvancedHEALTH will ask for identification of the person picking up patient medical information or products.



AdvancedHEALTH

# General Consent For Treatment

***As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).***

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. \_\_\_\_\_ (initial)

**I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.**

Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Consent of Legal Guardian, Patient Advocate or Nearest Relative if patient is unable to sign

Consent Caregiver if patient is unable to sign

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature of the above: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_



AdvancedHEALTH

# Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_



AdvancedHEALTH

# Patient Financial Policy

*This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.*

*In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.*

*Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.*

## **HEALTH INSURANCE - It is YOUR responsibility to:**

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurance's timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

## **It is OUR responsibility to:**

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

**PAYMENT OPTIONS:** Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

**We accept the following: Cash Check Credit Card (Visa, MasterCard, Discover, American Express)**

**A twenty-five dollar (\$25.00) returned check fee will be assessed to the patient account per incident.**

For convenience, payments may be made online at [www.ePayItOnline.com](http://www.ePayItOnline.com). To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. **Patients who no-show may be subject to a no-show fee.**

**PENDING APPROVALS FOR SERVICES:** In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

\_\_\_\_\_ Initials

Patient and/or Debtor Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*Additional financial explanations are continued on the back side of this page*



**AdvancedHEALTH**

**WORKERS' COMPENSATION INJURIES:** Written approval/authorization by your employer and/or workers' compensation carrier prior to your initial visit is needed. We will contact your case manager and/or supervisor to confirm your workers' compensation injury. If this claim is denied, for any reason by your employer or your employer's workers' compensation carrier, you will be responsible for payment in full. If denial is made by workers' compensation, health insurance can be filed for these denied services and you will be held responsible for the account.

**MOTOR VEHICLE ACCIDENTS (MVA's)** – Yes, I was involved in a MVA on \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_. Unless prior agreement has been reached or I am a Medicare recipient, my **health insurance** will be filed for services related to this accident. In the event I do not provide insurance information upon initial visit, I understand insurance denials may occur depending on type of service(s) received or carrier specific filing requirements. I agree, as the patient or patient's guardian, I am ultimately responsible for all balance(s) due to this facility and/or its physician(s) for services rendered regardless of insurance denial(s) or unfavorable case outcomes. If I have chosen an attorney to oversee my case, this financial agreement will serve as a Letter of Protection to my attorney. I further understand my account may be handled by an outside entity that specializes in attorney lien accounts at the facilities discretion.

\_\_\_\_ Yes, I have chosen to retain an attorney. Signed: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### BILLING INFORMATION

#### STATEMENTS:

A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <\$5.00> will not be refunded without specific request from the patient/debtor.

#### DELINQUENT ACCOUNTS:

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non emergency treatment for any and all debtor-related unpaid account balances.

#### WAIVER OF CONFIDENTIALITY:

You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

#### MEDICAL RECORDS:

You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. If the request is for a party other than the originally billed insurance and/or party, a **\$20.00 medical records fee** will be required on each occasion.



AdvancedHEALTH



**Franklin Gastroenterology, PLLC**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Health Information**

Chief complaint: \_\_\_\_\_

Other Active Medical Problems:

1. \_\_\_\_\_ 3. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_

Medication Allergies or Reactions \_\_\_\_\_

Explain: \_\_\_\_\_

Other Known Allergies: \_\_\_\_\_

Present Medications:

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Frequently Used Non-Prescription Medications:

Aspirin: \_\_\_\_\_ How Much: \_\_\_\_\_ How Often: \_\_\_\_\_

Laxatives: \_\_\_\_\_ How Much: \_\_\_\_\_ How Often: \_\_\_\_\_

Other: \_\_\_\_\_ How Much: \_\_\_\_\_ How Often: \_\_\_\_\_

Do you eat sugarless mints, candy or chew gum? \_\_\_\_\_

Do you drink milk or eat dairy products? \_\_\_\_\_

Previous Hospitalizations/Surgery (Please List All):

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_  
6. \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ Yes \_\_\_\_\_ No; Most recent date : \_\_\_\_\_

**Franklin Gastroenterology, PLLC**  
**Family History**

Mother: Alive: Yes \_\_\_\_\_ No \_\_\_\_\_ ; Age/Cause of Death: \_\_\_\_\_  
Father: Alive: Yes \_\_\_\_\_ No \_\_\_\_\_ ; Age/Cause of Death: \_\_\_\_\_

Please list the number of Brothers, Sisters and Children in each Category Below:

Brothers: Alive: Yes \_\_\_\_\_ No \_\_\_\_\_ ; Age/Cause of Death: \_\_\_\_\_  
Sisters: Alive: Yes \_\_\_\_\_ No \_\_\_\_\_ ; Age/ Cause of Death: \_\_\_\_\_  
Children: Alive: Yes \_\_\_\_\_ No \_\_\_\_\_ ; Age/Cause of Death: \_\_\_\_\_

Do any diseases "Run In Your Family"? Please explain:

\_\_\_\_\_

**Social History**

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ ; If so: how much/how often? \_\_\_\_\_  
Do you drink? Yes \_\_\_\_\_ No \_\_\_\_\_ ; If so: how much/how often? \_\_\_\_\_  
Any history of HIV+ or AIDS? Yes \_\_\_\_\_ No \_\_\_\_\_  
Any history of Tuberculosis (positive skin test of exposure)? Yes \_\_\_\_\_ No \_\_\_\_\_

**Current Medical Condition**

Please check appropriate response and briefly explain "yes" responses.

Constitutional Symptoms

Fever	Yes _____ No _____	_____
Weight Loss	Yes _____ No _____	_____
Weight Gain	Yes _____ No _____	_____
Night Sweats	Yes _____ No _____	_____

Eyes

Trouble with vision	Yes _____ No _____	_____
Dry Eyes	Yes _____ No _____	_____
Excessive Tearing	Yes _____ No _____	_____

Ear, Nose, Mouth and Throat

Trouble with hearing	Yes _____ No _____	_____
Tinnitus (ringing in ears)	Yes _____ No _____	_____
Epistaxis (nosebleeds)	Yes _____ No _____	_____
Trouble with smell	Yes _____ No _____	_____
Problems with bad breath	Yes _____ No _____	_____
Trouble with taste	Yes _____ No _____	_____
Mouth Ulcers	Yes _____ No _____	_____

## Franklin Gastroenterology, PLLC

### Ear, Nose and Throat (con't)

Frequent Sore Throat Yes \_\_\_\_\_ No \_\_\_\_\_  
Hoarseness Yes \_\_\_\_\_ No \_\_\_\_\_  
Lump in Throat Yes \_\_\_\_\_ No \_\_\_\_\_

### Cardiovascular

High blood pressure Yes \_\_\_\_\_ No \_\_\_\_\_  
Heart Murmur Yes \_\_\_\_\_ No \_\_\_\_\_  
Chest Pains Yes \_\_\_\_\_ No \_\_\_\_\_  
Palpitations Yes \_\_\_\_\_ No \_\_\_\_\_  
Ankle Swelling Yes \_\_\_\_\_ No \_\_\_\_\_

### Respiratory

Asthma or wheezing Yes \_\_\_\_\_ No \_\_\_\_\_  
Shortness of Breath Yes \_\_\_\_\_ No \_\_\_\_\_  
Chronic Cough (>3 weeks) Yes \_\_\_\_\_ No \_\_\_\_\_  
Blood sputum Yes \_\_\_\_\_ No \_\_\_\_\_  
Exposure to TB Yes \_\_\_\_\_ No \_\_\_\_\_

### Gastrointestinal

Constipation Yes \_\_\_\_\_ No \_\_\_\_\_  
Diarrhea Yes \_\_\_\_\_ No \_\_\_\_\_  
Rectal bleeding Yes \_\_\_\_\_ No \_\_\_\_\_  
Black Tarry stools Yes \_\_\_\_\_ No \_\_\_\_\_  
Change in bowel habits Yes \_\_\_\_\_ No \_\_\_\_\_  
Abdominal pain Yes \_\_\_\_\_ No \_\_\_\_\_  
Nausea or Vomiting Yes \_\_\_\_\_ No \_\_\_\_\_  
Heartburn Yes \_\_\_\_\_ No \_\_\_\_\_  
Indigestion Yes \_\_\_\_\_ No \_\_\_\_\_  
Trouble Swallowing Yes \_\_\_\_\_ No \_\_\_\_\_  
Jaundice or liver trouble Yes \_\_\_\_\_ No \_\_\_\_\_  
Hemorrhoids or fissures Yes \_\_\_\_\_ No \_\_\_\_\_  
Hernia Yes \_\_\_\_\_ No \_\_\_\_\_

### Genitourinary

Venereal disease Yes \_\_\_\_\_ No \_\_\_\_\_  
Frequent urination Yes \_\_\_\_\_ No \_\_\_\_\_  
Burning urination Yes \_\_\_\_\_ No \_\_\_\_\_

### Musculoskeletal

Arthritis Yes \_\_\_\_\_ No \_\_\_\_\_  
Joint Swelling Yes \_\_\_\_\_ No \_\_\_\_\_  
Chronic Muscle Pain Yes \_\_\_\_\_ No \_\_\_\_\_

Franklin Gastroenterology, PLLC

Integumentary (Skin and Breasts)

Itching problems Yes \_\_\_\_\_ No \_\_\_\_\_  
Rashes Yes \_\_\_\_\_ No \_\_\_\_\_  
Breast discharge Yes \_\_\_\_\_ No \_\_\_\_\_  
Painful breasts Yes \_\_\_\_\_ No \_\_\_\_\_  
Lumps in breasts Yes \_\_\_\_\_ No \_\_\_\_\_

Neurological

Seizures Yes \_\_\_\_\_ No \_\_\_\_\_  
Black out spells Yes \_\_\_\_\_ No \_\_\_\_\_  
Temporary loss of vision Yes \_\_\_\_\_ No \_\_\_\_\_  
Chronic headaches Yes \_\_\_\_\_ No \_\_\_\_\_

Psychiatric

Depression Yes \_\_\_\_\_ No \_\_\_\_\_  
Anxiety Yes \_\_\_\_\_ No \_\_\_\_\_  
Trouble Sleeping Yes \_\_\_\_\_ No \_\_\_\_\_

Endocrine

Diabetes Yes \_\_\_\_\_ No \_\_\_\_\_  
Thyroid Problems Yes \_\_\_\_\_ No \_\_\_\_\_

Hematological/Lymphatic

Anemia Yes \_\_\_\_\_ No \_\_\_\_\_  
Other blood problems Yes \_\_\_\_\_ No \_\_\_\_\_  
Other bleeding issues Yes \_\_\_\_\_ No \_\_\_\_\_  
Swollen glands Yes \_\_\_\_\_ No \_\_\_\_\_

Allergies

Allergies Yes \_\_\_\_\_ No \_\_\_\_\_  
Sinus problems Yes \_\_\_\_\_ No \_\_\_\_\_  
Food allergies Yes \_\_\_\_\_ No \_\_\_\_\_  
Contact allergies Yes \_\_\_\_\_ No \_\_\_\_\_

Women only

Irregular Menstrual Cycles Yes \_\_\_\_\_ No \_\_\_\_\_  
Painful Menstrual Cycles Yes \_\_\_\_\_ No \_\_\_\_\_  
Painful Intercourse Yes \_\_\_\_\_ No \_\_\_\_\_  
Age at Menopause Yes \_\_\_\_\_ No \_\_\_\_\_  
Birth Control Yes \_\_\_\_\_ No \_\_\_\_\_  
Could be pregnant Yes \_\_\_\_\_ No \_\_\_\_\_

Any other concerns: \_\_\_\_\_

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_