THE PAT SUMMITT CLINIC
1932 ALCOA HIGHWAY
MEDICAL BUILDING C, SUITE 150
KNOXVILLE, TN 37920
Phone (865) 305-CARE (2273)
Fax (865) 305-7311

TO: _____

APPOINTMENT DATE/TIME: _____

LOCATION: **University of Tennessee Medical Center, Medical Bldg. C, Suite 150**

Please complete the enclosed New Patient Health History questionnaire and bring it with you to your appointment. You *do not* need to fill out the medication list in the packet. Please bring your medicine bottles or an up to date list of your medicines.

Please arrive **30** minutes prior to your scheduled appointment. Arrival 15 minutes past the scheduled appointment time may result in the appointment being rescheduled to the next available opening.

We ask that if you need to cancel or reschedule an appointment, please call our office 24 hours ahead of time. Doing so allows our team to fill the appointment slot and assist another patient that has been waiting for an appointment.

If you have any questions or need assistance completing this packet, please call the office at (865) 305-CARE (2273).

PATIENT INFORMATION SHEET

Name of Patient: _____
Last First Middle

Mailing Address _____
Street Apt# City State Zip

Home Phone: (_____)_____Cell: (_____)_____Occupation: _____

Social Security #_____Birthdate:_____/_____ /_____ Age:_____Sex: _____

__ Child (under 18) Single Adult __Married __Widowed Separated __Divorced

Employer's Name:_____Phone: (_____) _____

Complete Address: _____

Wife, husband
Or Parent:_____SS# of Parent or Spouse:_____

Employer:_____Phone: (_____)_____Birthdate:_____/_____/_____

Complete Address: _____

Name of nearest relative (not living with you) or name of your Power of Attorney:

_____ Relationship:_____Phone: (_____) _____

Family Doctor:_____Phone: (_____) _____

Pharmacy:_____Phone: (_____) _____

Who referred you to us?_____Phone: (_____) _____

Are you allergic to any medication:____No ___Yes List: _____

Is there a chance you might be pregnant?____No_____Yes

Do you have an advance care plan?____No_____Yes *Photocopy to chart*

Do you have a health care agent?____No_____Yes *Photocopy to chart*

I authorize this physician to release any information acquired in the course of my examination or treatment to my insurance carrier(s). I hereby authorize payment directed to my physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services. I recognize that my charges will be divided between the physician and UT Hospital. My insurance will be billed by both parties.

I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR ANY BALANCE OR FEE NOT COVERED AND OR ANY COST OF COLLECTION.

SIGNED:_____DATE: _____

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PATIENT PRIVACY QUESTIONNAIRE

Patient's Name: _____

1. May we leave confidential messages with anyone who answers your phone?
   Yes ❑ No ❑

2. May we leave confidential messages regarding appointments, return calls for test results, etc. on your home answering machine or voicemail? Yes ❑ No ❑

3. May we leave confidential messages with anyone who answers your phone regarding appointments, lab results or other healthcare information at numbers other than your home number? Yes ❑ No ❑

   If yes, please list the numbers: _____

4. If we are unable to reach you by any of the above options, may we leave confidential messages at your place of employment? Yes ❑ No ❑ N/A ❑

If we are unable to reach you be any other means, we will send information through the US Postal Service to your Home address.

A copy of the University Health System, Inc. (UHS) Notice of Information Practices has been made available to me. I understand that this Notice describes how my health information may be used or disclosed by UHS and physicians and other providers practicing at UHS and that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (865) 305-9118 or on the website at www.utmedicalcenter.org, or by requesting one at a UHS office.

_____ _____

Signature of patient (or guardian if under age 18) Date

UNIVERSITY OF TENNESSEE MEDICAL CENTER
1932 ALCOA HWY SUITE C 150 KNOXVILLE, TN 37920
(865) 305-2273

LABEL

THE PAT SUMMITT CLINIC
HEALTH HISTORY QUESTIONNAIRE & PROBLEM LIST

NAME:_____ SS#/DOB_____ DATE:_____
(Last, First, MI)

Please list your doctors (starting with the doctor who referred you here):

Doctor and Specialty

_____ Primary Physician:_____

_____ Referring Physician:_____

_____ _____

CHIEF COMPLAINT

What is the reason for your visit today? _____

_____

_____

- Please complete attached Medication List -

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Operation: **Age or Year:**

Clinical Trial: **No Yes** **Flu: date**_____ **Pneumococcal: date** _____

Other Hospitalizations:

Year: **Reason:**

Previous Hospital Isolation ☐ Yes ☐ No Type: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed _____Number of Marriages

((All questions contained in this questionnaire are optional and will be kept strictly confidential.))

Is patient or spouse a veteran? _Yes ___No

Is there a history of abuse?
Verbal ___Yes ___No
Sexual ___Yes ___No
Physical ___Yes ___No

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

Alcohol: Do you drink alcohol? ☐ Yes ☐ No If yes, what kind?_____How many drinks per week? _____

Drugs: Do you currently use recreational or street drugs (cocaine, methamphetamine, marijuana, etc)? ……. ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? …….. ☐ Yes ☐ No

Tobacco:
Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes – Packs/day_____ ☐ Chew - #/day_____ ☐ Pipe - #/day_____
Are you around other smokers? ☐ Yes ☐ No ☐ Cigars - #/day_____ ☐ # of Years_____ ☐ or Year Quit _____

Toxic Exposures: Please list any (lead, arsenic, solvents, mercury, etc) _____
_____

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

REVIEW OF SYSTEMS:

GENERAL

Have you had recent fever? …….. ☐ Yes ☐ No
Have you had recent weight loss? …… ☐ Yes ☐ No
Do you have frequent / severe night sweats? ……..☐ Yes ☐ No

ENDOCRINE

Do you have thyroid problems or goiter? ☐ Yes ☐ No
Do you have diabetes? ☐ Yes ☐ No

HEAD, EYES, EARS, NOSE, AND THROAT

Do you have vision (eyesight) problems? ☐ Yes ☐ No
Do you have dry eyes? ☐ Yes ☐ No
Do you have trouble hearing? ☐ Yes ☐ No
Do you have ringing in your ears? ☐ Yes ☐ No
Do you have nosebleeds? ☐ Yes ☐ No
Do you have hoarseness? ☐ Yes ☐ No
Do you have sinus problems? ☐ Yes ☐ No
Do you have dry mouth? ☐ Yes ☐ No

GASTROINTESTINAL

Do you have trouble swallowing? ☐ Yes ☐ No
Do you have indigestion or heartburn? ☐ Yes ☐ No
Have you had ulcers? ☐ Yes ☐ No
Do you have frequent constipation? ☐ Yes ☐ No
Do you have frequent diarrhea? ☐ Yes ☐ No
Have you had hepatitis or liver disease (yellow jaundice)? ☐ Yes ☐ No
Do you have gallbladder disease? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No

PULMONARY

Do you have shortness of breath? ☐ Yes ☐ No
Do you have wheezing, asthma, or emphysema? ☐ Yes ☐ No
Have you had tuberculosis or a positive TB test? ☐ Yes ☐ No
Home Oxygen/Sleep Apnea/ CPAP ☐ Yes ☐ No

CARDIOVASCULAR

Do you have hypertension (high blood pressure)? ☐ Yes ☐ No
Do you have heart disease (heart attack, heart failure, valve problem)? ☐ Yes ☐ No
Do you have a heart murmur? ☐ Yes ☐ No
Does your heart beat fast or slow (palpitations)? ☐ Yes ☐ No
Do you have high cholesterol? ☐ Yes ☐ No
Current Vascular Access (ports, Dialysis Access, etc.) ☐ Yes ☐ No

HEMATOLOGIC

Do you bleed or bruise easily? ☐ Yes ☐ No
Do you have anemia (low blood count)? ☐ Yes ☐ No
Do you have a history of B12 deficiency or Iron deficiency? ☐ Yes ☐ No

RHEUMATOLOGIC

Do you have a history of any rheumatologic disease (Lupus, Sjogrens Syndrome, etc)? ☐ Yes ☐ No
Do you have arthritis or joint pain/swelling? ☐ Yes ☐ No
Do you have back or neck pain? ☐ Yes ☐ No

NEUROLOGIC

Do you have headaches? ☐ Yes ☐ No
Have you ever had a seizure or convulsion? ☐ Yes ☐ No
Do you have a loss of sensation (numbness) anywhere? ☐ Yes ☐ No
Do you have a loss of muscle power anywhere? ☐ Yes ☐ No
Do you have tremor (shaking)? ☐ Yes ☐ No
Have you had a concussion or whiplash injury? ☐ Yes ☐ No
Do you have trouble sleeping? If so, what trouble? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
Do you fall asleep driving or similar activity? ☐ Yes ☐ No
Do you have trouble walking? ☐ Yes ☐ No
Do you have trouble with your speech? ☐ Yes ☐ No
Do you have frequent dizziness? ☐ Yes ☐ No
Do you have motion sickness? ☐ Yes ☐ No
Do you have double vision? ☐ Yes ☐ No
Have you ever had a stroke? ☐ Yes ☐ No

DERMATOLOGIC

Do you have any skin problems (rashes, acne, moles, etc)? ☐ Yes ☐ No
Have you had malignant melanoma? ☐ Yes ☐ No
Have you had any other form of skin cancer? ☐ Yes ☐ No

PSYCHOLOGIC

Is stress a major problem for you? ☐ Yes ☐ No
Do you feel depressed? ☐ Yes ☐ No
Do you panic when stressed? ☐ Yes ☐ No
Do you have problems with eating or your appetite? ☐ Yes ☐ No
Do you cry frequently? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No
Have you ever been to a counselor? ☐ Yes ☐ No

What degree of stress do you have:

At Home? _____

At Work? _____

Other? _____

WOMEN ONLY – GENITOURINARY

Number of Pregnancies_____Number of live births _____
Have you ever had a miscarriage (in which month did it happen)? ☐ Yes ☐ No
Are you pregnant or breastfeeding? ☐ Yes ☐ No
Have you had a hysterectomy? ☐ Yes ☐ No
Have you had any bladder problems in the past year? ☐ Yes ☐ No
Any problems with control of urination? ☐ Yes ☐ No
Have you had kidney disease? ☐ Yes ☐ No

MEN ONLY – GENITOURINARY

Do you usually get up to urinate during the night? ☐ Yes ☐ No If yes, # of times _____
Do you have any bladder problems? ☐ Yes ☐ No
Any difficulty with erection or ejaculation? ☐ Yes ☐ No
Do you have any prostate problems? ☐ Yes ☐ No
Have you had kidney disease? ☐ Yes ☐ No

THE PAT SUMMITT CLINIC
Medication Sheet

LABEL

NAME:_____SS#/DOB_____DATE: _____

PHYSICIAN: _____

ALLERGIES/ ADVERSE REACTIONS: _____

Medication **Dosage** **Frequency**	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**	**DATE**

Special Needs:

Do you have any special needs?

No Yes

___ ___Wheelchair/walker/cane
___ ___Reading/writing
___ ___Hearing
___ ___Language Barrier*
___ ___Do you have any nutritional needs

*Obtain CyraCom interpreter system

How do you prefer to receive information? _____verbal_____written

Other: _____

Patient Rights:

No Yes Do you have an advanced care plan?
Photocopy to chart No Yes

No Yes Do you have a health care agent?
Photocopy to chart No Yes

If patient has these documents were they or family instructed to provide copy? No Yes
If patient does not have advanced care plan or health care agent, was information given? No Yes

Psychosocial/Spiritual:

No Yes Do you have any fears or anxieties we need to be aware of such as fear of needles, closed-in spaces, etc.?

No Yes Do you have any special religious or cultural needs?

Infection Prevention:

No Yes Patient/Family verbalizes understanding of hand hygiene and respiratory precautions as stated below:

- Wash your hands
- Expect health care providers to wash their hands or wear gloves.
- Cover your mouth and nose when coughing or sneezing.
- If you are sick, avoid close contact with others.
- Get immunizations to avoid disease.

DOCTOR'S REVIEW

Pain Level: _____

0= No Pain, 1-2 = Mild Pain, 3-4 = Moderate Pain, 5-6 = Severe Pain, 7-8 = Very Severe Pain, 9-10 = Worst Possible Pain

Evidence of abuse/neglect? _____

Risk for Falls: low_____(0-2) Moderate_____(3 – 4) High_____(5 or >)

Instructed in falls prevention_____

Assessment based on age, mobility, mental status, bathroom independence, fall history, current medications and physician judgment.

This form was reviewed with patient.

_____ _____ _____/_____/_____ _____
Physician Signature Contact# Date Time

Complete Medication Reconciliation form for all patients as applicable to your area.
Date:_____Time:_____Form Completed by: _____

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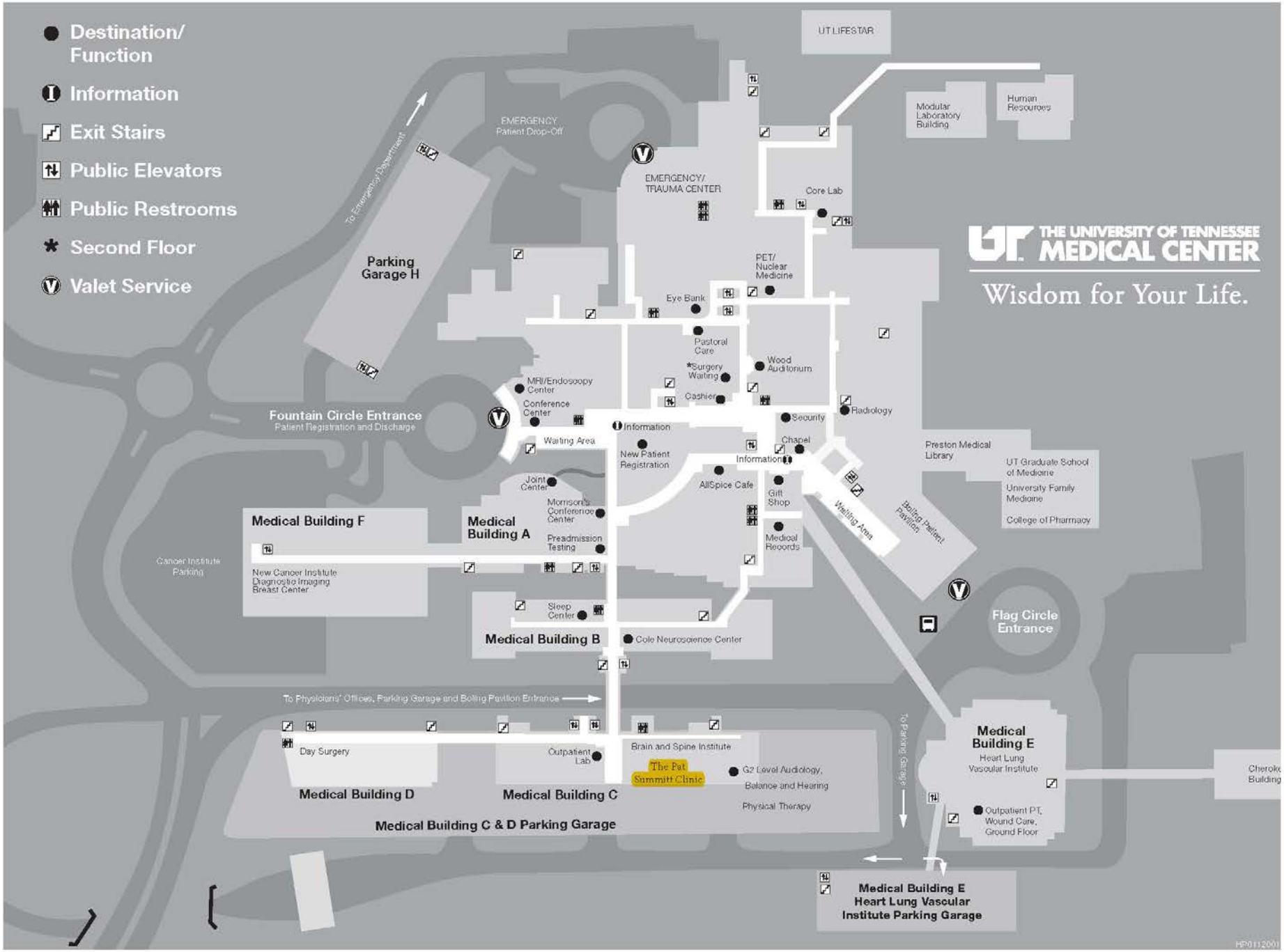
DRIVING DIRECTIONS FROM EITHER I-40 EAST OR WEST:
Take the 129 (Alcoa Highway) exit (386B). Travel south on 129 – approximately one mile to the UT Medical Center/Cherokee Trail exit. Follow the exit onto the medical center campus.

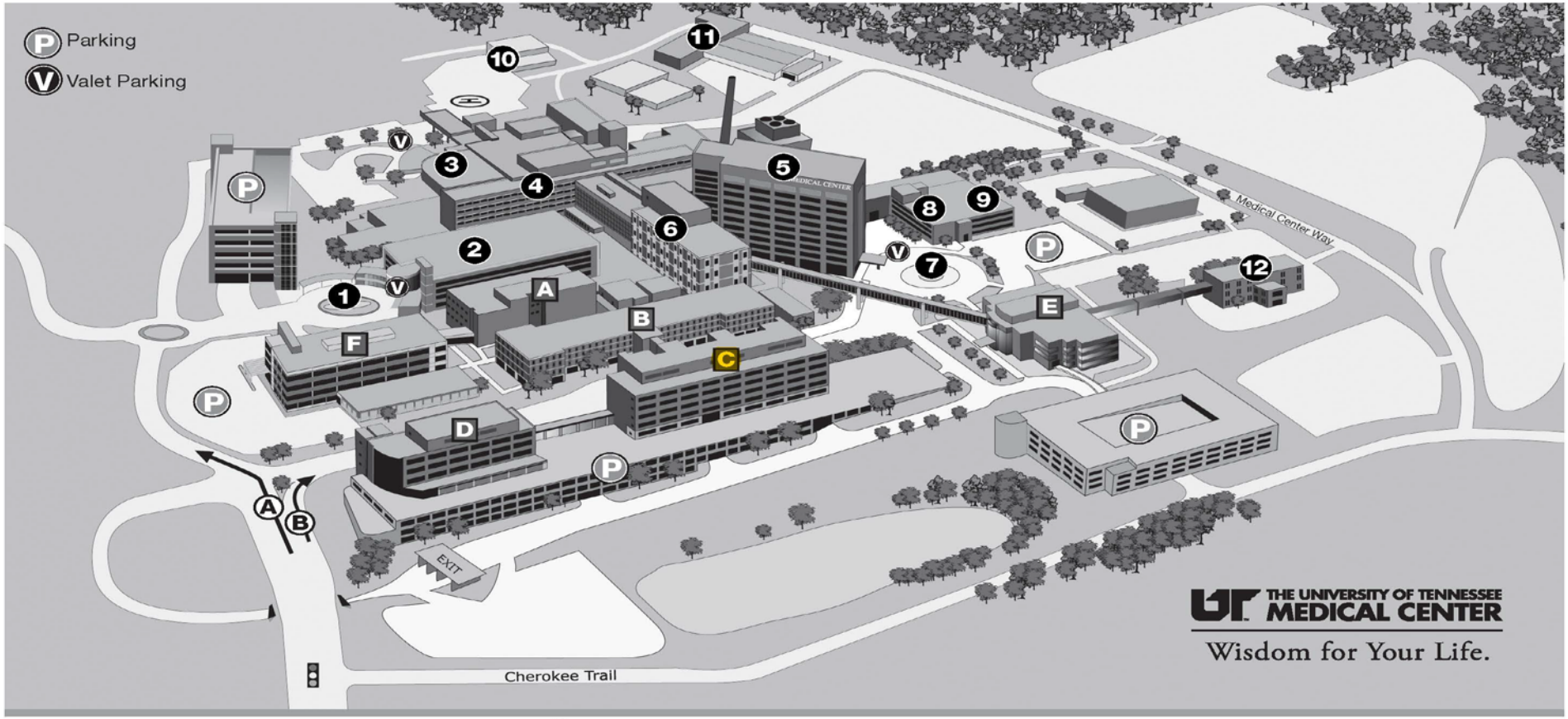
DRIVING DIRECTIONS FROM THE AIRPORT:
Take the Knoxville exit from the airport. This will take you to Alcoa Highway (north 129). Travel on Alcoa highway (north 129) for approximately 10 miles and exit right at the medical center/Cherokee Trail exit. The Marine Corps Armory is on left just before you exit right.

Exit Alcoa Highway and proceed straight toward the main entrance of the medical center. Do not veer right onto Cherokee Trail. Take the first right turn marked "Physician's Office Buildings." Proceed through the connecting crosswalk and turn right through the parking gates. The right lane will take you to the Building C and D parking garage. Park in this garage and come to the first floor in Building C. The Pat Summitt Clinic is located in Building C, Suite 150.

Valet parking is available for $5 at the Flag Circle and Fountain Circle Entrances of the hospital between 7 am and 5:30 pm Monday through Friday. General Parking Garage rates are $2 per day.

We look forward to meeting you!


Destination/ Function
Information
Exit Stairs
Public Elevators
Public Restrooms
Second Floor
Valet Service
UT LIFESTAR
Modular Laboratory Building
Human Resources
EMERGENCY Patient Drop-Off
To Emergency Department
EMERGENCY/ TRAUMA CENTER
Core Lab
THE UNIVERSITY OF TENNESSEE MEDICAL CENTER
Wisdom for Your Life.
Parking Garage H
PET/ Nuclear Medicine
Eye Bank
Pastoral Care
*Surgery Waiting
Wood Auditorium
MRI/Endoscopy Center
Conference Center
Cashier
Radiology
Fountain Circle Entrance
Patient Registration and Discharge
Information
Security
Waiting Area
New Patient Registration
Chapel
Information
Preston Medical Library
UT Graduate School of Medicine
University Family Medicine
College of Pharmacy
Joint Center
AllSpice Cafe
Gift Shop
Morrison's Conference Center
Medical Building F
Medical Building A
Preadmission Testing
Medical Records
Boling Pavilion
Waiting Area
Cancer Institute Parking
New Cancer Institute Diagnostic Imaging Breast Center
Sleep Center
Flag Circle Entrance
Medical Building B
Cole Neuroscience Center
To Physicians' Offices, Parking Garage and Boling Pavilion Entrance
To Parking Garage
Medical Building E
Heart Lung Vascular Institute
Day Surgery
Outpatient Lab
Brain and Spine Institute
The Pat Summitt Clinic
G2 Level Audiology, Balance and Hearing
Physical Therapy
Outpatient PT, Wound Care, Ground Floor
Medical Building D
Medical Building C
Medical Building C & D Parking Garage
Medical Building E Heart Lung Vascular Institute Parking Garage
HP0112001



Route A: To Hospital/Main Entrance, Parking Garage, Emergency Dept, MRI, Endoscopy and Cancer Institute

Route B: To Medical Offices and Parking Garage

1. Fountain Circle
2. Heart Hospital, Endoscopy Center, MRI
3. Emergency/Trauma
4. North Tower
5. Boling Patient Pavilion
6. South Pavilion
7. Flag Circle
8. UT Graduate School of Medicine
   University Family Medicine
9. UT College of Pharmacy
10. UT LIFESTAR
11. Human Resources/
    Facilities Planning
12. Cherokee Trail Building

Medical Office Buildings

- A Medical Building A
- B Medical Building B
- C Medical Building C-*Brain and Spine Institute*
- D Medical Building D-*UT Day Surgery*
- E Medical Building E-*Heart Lung Vascular Institute*
- F Medical Building F-*Cancer Institute*