Addison Internal Medicine

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:
Date of Birth (Age):	Gender: ☐ Female ☐ Male	Marital Status: ☐ Married ☐ Single ☐ Divo ☐ Widowed ☐ Separated
Ethnicity: : ☐ Caucasian ☐ African-American ☐ Asian/Pacific Islander ☐ Hispanic ☐ Native-American ☐ Other	Social Security No.:	Email Address:
Address:	City, State, Zip Code:	Language/Translator needed: ☐ Yes ☐ No
Home No: Cell No: Work No:	☐ OK to leave detailed message at home/cell number. ☐ OK to mail/fax to my home address/number. ☐ OK to send text/email (portal)	Employment Status: ☐ Employed ☐ Retired ☐ Self-Employed ☐ Unemployed
Student Status: ☐ Full-Time ☐ Part-Time	Employer/ School:	Occupation:
Employer/ School Phone No.:	Referring Provider Name:	Advanced Directives (EX: DNR, Living Wil ☐ Yes ☐ No

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home Phone No.:

INSURANCE INFORMATION

Primary Health Insurance

Insurance Company:	Plan:	
Subscriber ID No.:	Group No.:	Copay:
Insured's Name (as it appears on insurance card):	Relation to Patient:	Date of Birth (Insured):
Insured's Address:	City and State:	Zip Code:

Secondary Health Insurance (if applicable)

Name of secondary insurance (if applicable):	Subscriber's Name:	Policy No.:	Group No.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Addison Internal Medicine or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____

16980 Dallas Parkway, Suite 110, Dallas, TX 75248
Phone: 972-733-3090 | Fax: 972-733-4565 |www.AddisonInternalMedicine.com

Addison Internal Medicine

Patient General Consent to Treat

I, _____ the undersigned, hereby consent to the following:

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Addison Internal Medicine may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

Pharmacy Info/RX History Consent

We, at Addison Internal Medicine are very pleased that you have chosen us as your primary healthcare provider. In order to better serve you, your prescriptions will now be electronically processed directly to your pharmacy. Please provide us with your pharmacy information in the space provided below.

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

By signing this consent, you are authorizing Addison Internal Medicine to view your prescription history from external sources.

_____ _____

Patient (or responsible party) Signature Date

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Addison Internal Medicine
Patient HIPAA Form

Patient Name: _____ Date of Birth: _____ Date: _____

Notice of Privacy Practices Acknowledgement

_____ (Patient initials) I acknowledge that I have received Addison Internal Medicine Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Addison Internal Medicine Notice of Privacy Practices.

Release of Information

_____ (Patient initials) I permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

1. Name: _____Relationship: _____ Phone No.: _____
2. Name: _____Relationship: _____ Phone No.: _____
3. Name: _____Relationship: _____ Phone No.: _____

_____ _____

Patient (or responsible party) Signature Date

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Addison Internal Medicine

Patient Responsibility Form

Thank you for choosing Addison Internal Medicine for all your medical needs. We look forward to providing you a complete package of medical treatment. We file your charges to your insurance carrier as a benefit to you. It is, however, the patient's responsibility to know and understand what service is covered under the policy. To help keep healthcare costs down, we ask the following payments to be made on your account prior to being seen by your doctor. Any outstanding balance owed is due after your visit with your physician, payable at the front desk check in. For your convenience we accept cash, check and most major credit cards. There is a $25 fee for return checks.

INSURED: Your co-pay, in accordance with your insurance plan, is due at check-in. If you have a deductible plan, please note that $100 pre-payment will be collected at check in. Once we receive payment from your insurance, you will be billed for any balance owed. Because we are obligated under contract with your insurance company, this balance cannot be adjusted off your account.

UNINSURED: If you are a new patient $215.00 will be due at the time of check in. If you are an established patient $145.00 will be due at the time of check-in. Payment collected at check-in does not include any additional services such as labs, EKG, X-ray's or injections. Payment for these services will be due at check-out. Overpayments resulting in a credit balance will be applied to any outstanding balances on your account.

Motor Vehicle Accidents: If you are seeing one of our physician's due to a motor vehicle accident, payment must be made at the time of your appointment. We do not file claims to automobile insurance companies therefore; it will be your responsibility to provide your bills and receipts from Addison Internal Medicine to your Insurance Company. We will not file claims to Worker's Compensation.

Common Insurance denials include but are not limited to: Pre-Existing condition, insurance not in effect at the time of services, coverage by more than one plan in which coordination of benefits has not been arranged, policy maximum has been reached, or medical services rendered are not covered by the insurance policy. All unpaid balances remain the patient/guarantor responsibility.

How you can assist in several ways to expedite your claim and reduce denials: You will be asked when you check in at every visit to provide a picture ID, verify your personal information and make any changes so that your account can be updated. It is your responsibility to inform us of any demographic and insurance changes. If you have two or more insurance carriers, please advise us and provide a copy of both cards.

No show, cancellation and late patient policy: If you are unable to keep a scheduled appointment, please give 24-hour notice to ensure that you will not be charged the $50 no show fee. If there are three or more scheduled appointments which you do not keep without prior cancellation or if there are repeated scheduled appointments in which you arrive fifteen minutes late, you could be subject to dismissal from our practice.

FMLA/Disability paperwork: Blank forms will not be accepted. Personal information must be completed. Paperwork will be completed on or before 7 business days. Forms are completed for those accounts in good standing. Outstanding balances must be paid prior to forms being filled out. There is $25 fee due when forms are completed.

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf based on the information I provide. Both Addison Internal Medicine and I will receive an EOB (explanation of benefits) from my insurance carrier(s) that will detail any payments, deductions and adjustment per my plan's guidelines.

I understand that I will be fully responsible for payment of all medical services denied by my insurance company as applicable by state and/or federal law.

_____ _____

Patient (or responsible party) Signature Date

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NOTICE OF PRIVACY PRACTICES

Effective Date: 8/15/2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Facility Privacy Official by dialing the main facility number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

To business associates we have contracted with to perform the agreed upon service and billing for it;
To remind you that you have an appointment for medical care;
To assess your satisfaction with our services;
To tell you about possible treatment alternatives;
To tell you about health–related benefits or services;
To contact you as part of fundraising efforts, unless you elect not to receive any such communications;
To inform Funeral Directors consistent with applicable law;
For population based activities relating to improving health or reducing health care costs; and
For conducting training programs or reviewing competence of health care professionals.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Directory: We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (e.g., good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or Facility Privacy Official.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

Food and Drug Administration
Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
Correctional Institutions
Workers Compensation Agents
Organ and Tissue Donation Organizations
Military Command Authorities
Health Oversight Agencies
Funeral Directors, Coroners and Medical Directors
National Security and Intelligence Agencies
Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy

laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the Right to:

Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Facility Privacy Official.

We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in

writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

FACILITY PRIVACY OFFICIAL Telephone Number: (972) 733-3090

Authorization for Release of Information

I hereby authorize _____
(Entity/Person from Whom Records are Requested)

_____
(Full and Complete Address)

_____
(Office Number and Fax Number, if available)

to disclose my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Patient Name _____ Date of Birth _____ Social Security Number _____

Date(s) of service (if known): _____

Description of information to be released (check all that apply):

____Emergency Room	____Radiology reports	____Admission/Registration
____History & Physical	____Consultation reports	____Physician's orders
____Laboratory reports	____Progress Notes	____Operative records
____Billing records	____Discharge summary	____Radiology films

____Others: _____

Description of the purpose of the use and/or disclosure: _____

The health information described herein shall be released to (check the appropriate category):

____Hospital; _____Physician; _____Insurance Company; _____Attorney; _____Patient; _____Other

Physician Name _____

Address _____

City _____ State _____ Zip _____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____.
(Expiration event/date)

I further understand that I may revoke this authorization at any time by notifying in writing at _____.
I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative _____ Date _____

Printed Name of Patient or legal Representative _____

Relationship to Patient or Legal Authority (attach supporting documentation): _____

16980 Dallas Parkway, Suite 110
Dallas, TX 75248
(972) 733-3090 Office
(972) 733-4565 Fax
www.AddisonInternalMedicine.com

Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Women Only:

of Pregnancies _____ # of Miscarraiges _____ # of Abortions _____ # of Living _____

Last Pap Smear _____ Last Mammogram _____ Birth Control Method _____

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Name _____ Gender _____ Age _____ Date of Appointment: _____

Review of Systems

General
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth – Excessive
- ☐ Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst - Excessive
- ☐ Weight Gain
- ☐ Weight Loss

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Interest
- ☐ Feeling Hopeless
- ☐ Hearing Voices
- ☐ Marital Problems
- ☐ Panic Attacks
- ☐ Trouble Concentrating
- ☐ Suicide –Thoughts/Attempts

Skin
- ☐ Acne
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Chills
- ☐ Dry / Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores That Won't Heal

Gastrointestinal
- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal Disorder
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination

Neurological
- ☐ Coordination Problems
- ☐ Convulsions
- ☐ Difficulty Walking
- ☐ Learning Disabilities
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tremors

ENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Halos

Respiratory
- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pains
- ☐ Irregular Heart Beat
- ☐ Circulation Problems
- ☐ Heart Palpitations
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Musculoskeletal
- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Shoulder Pain

Men Only
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penile Discharge
- ☐ Sore on Penis

Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge

Other Symptoms

_____

_____

_____

Health Exams & Procedures

Please check and date the last time you had each exam or procedure performed.

	Month & Year		Month & Year
☐ Cholesterol Test	_____	☐ MRI	_____
☐ Colonoscopy	_____	☐ Physical Exam	_____
☐ CT/CAT Scan	_____	☐ Cardiac Stress Test	_____
☐ EKG	_____	☐ Ultra Sound	_____
☐ Echocardiogram	_____		

Immunizations

Please check and date all immunizations you have had.

	Month & Year		Month & Year
☐ Hepatitis A	_____	☐ MMR (Measles, Mumps, Rubella)	_____
☐ Hepatitis B (Series of 3)	_____	☐ Pneumonia	_____
☐ HPV Vaccine	_____	☐ Polio	_____
☐ Influenza (Flu Shot)	_____	☐ Tetanus	_____
☐ Meningitis	_____		