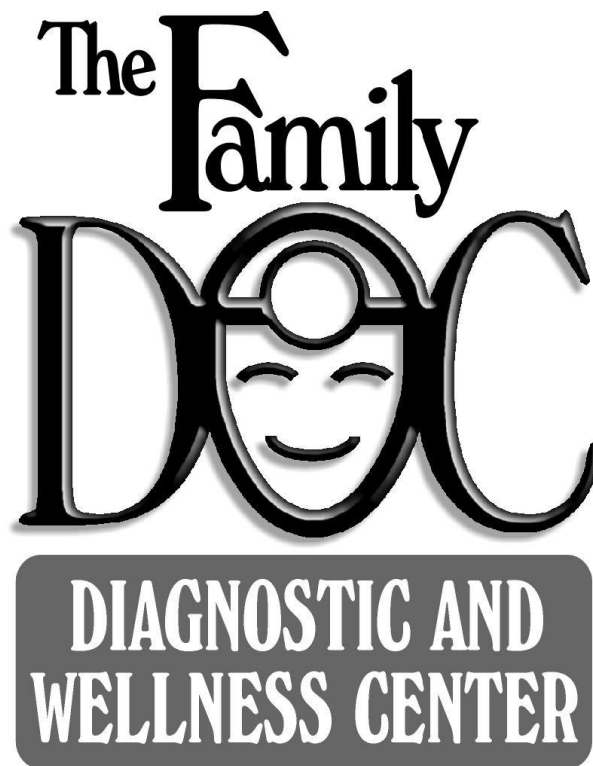


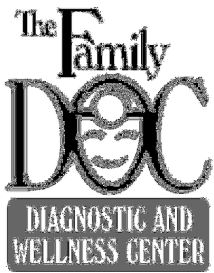
New Patient Packet



The Family Doc Diagnostic & Wellness Center

1411 Greenway Court, Sanford NC 27330

(919)776-3750 Office (919)776-3760 Fax www.TFDsanford.com



1411 Greenway Court
Sanford, NC 27330
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Thank you for choosing *The Family Doc, Diagnostic & Wellness Center* as your primary health-care provider. We will make every effort to make your visit as pleasant as possible. As a Family Medical Practice, Dr. Patterson and his staff can treat your entire family's health needs from infancy to adulthood. Our services range from routine health exams to comprehensive wellness programs to in-house surgical and diagnostic procedures such as mole removal and bone density scanning, among others.

Since this will be your first visit, we will perform a broad exam, exploring your family and recent medical history. Please allow two hours from the time you arrive for us to complete your examination.

In order to expedite your first visit, please look over and complete the forms included in this packet before you arrive for your appointment. By bringing these completed forms in before your first appointment, you will eliminate your waiting time and allow us to "build a chart" for you. If you have any questions about any of these forms, please feel free to call our office for assistance.

Enclosed are the following forms:

- ⇒Patient Data Sheet
- ⇒Financial Policy & HIPPA
- ⇒Authorization for Release of Medical Records
- ⇒Comprehensive History & Physical Forms

Please be prepared to offer payment for services on the day of your appointment. The Family Doc accepts cash, checks, and major credit cards. The Family Doc also participates in many insurance plans and will file all insurance plans.

Please remember to bring these items for your first visit:

- ⇒Medications & Vitamins you are currently taking
- ⇒Your most current immunization record.
- ⇒A list of questions and concerns to discuss with your Medical Provider.
- ⇒Insurance Card and form of payment.

Thank you once again for choosing *The Family Doc*, you complete health care resource. We truly feel our patients are our most important asset and we pledge to you our best!

We look forward to seeing you soon.

Sincerely,

ROBERT W. PATTERSON, MD AND THE ENTIRE FAMILY DOC STAFF



Authorization For Release of Medical Records

Patient Name: _____ Chart Number: _____

Social Security Number: _____ Date of Birth: ____/____/____

To Doctor: _____
(Name of Physician/Facility We Need To Get Records From)

Address: _____
(Address of Physician/Facility)

I, the undersigned, authorize you to furnish copies of the following medical records to Dr. Robert W. Patterson/
The Family Doc – Diagnostic & Wellness Center of the following:

- Copies of All Hospital Reports for the Date of _____ to _____
- Outpatient Records
- Doctor’s Office Notes
- X-ray Reports
- Laboratory Reports

Other _____

I authorize the release for the following purpose and for that purpose only. Any other use is forbidden.

Reason for release: _____

- This authorization specifically authorizes you to disclose records of alcohol abuse and substance abuse.
- This authorization specifically authorizes you to disclose HIV test results or diagnosis and AIDS/AIDS-related conditions.
- This authorization specifically authorizes you to disclose records of mental health disorders.

I also understand that I may revoke the authorization at any time, except to the extent that Dr. Patterson/The Family Doc – Diagnostic & Wellness Center has already taken action in reliance on it (e.g., probation, parole, etc.) and that in any event, this authorization expires automatically within thirty (30) days from the date of my signature or as otherwise specified by date, event, or condition(s) as follows: _____.

Signature of Patient: _____ Date: _____

Legal Representative (if patient is unable to sign) _____

Witness: _____ Date: _____



Financial Policy and Notice of Privacy

I have received a copy of The Family Doc's Financial Policy and Privacy Practices and agree to abide by the rules and regulations of these policies. This signed document will be placed in my medical chart and is valid for one year from the time of signing. **(Initial here)** _____

As parent/guardian I give my consent for my child (children) to be treated at **The Family Doc Diagnostic & Wellness Center**. I agree that I am financially responsible/liable for any services rendered.

_____ &/or _____ has permission to bring my child for treatment.

Parent or Guardian Signature: _____ Date: _____

Authorization for Release of PHI (Personal Health Information) or Medical Information

I _____, date of birth _____,

Hereby authorize **The Family Doc Diagnostic & Wellness Center** to release my PHI or medical information to:
(Specific Person(s) or Entity Authorized to Received PHI or medical information)

Name(s): _____

I request the method for leaving my medical information:

- May be left on home answering machine: YES NO # _____
- May be left on my cell phone YES NO # _____
- Via Email: _____ Fax # _____
- Mail- Address _____

Emergency Contact: _____ **Relationship:** _____ **Number:** _____

Signature: _____
(Patient/Guardian/Personal Representative)

Print Name: _____ Date Signed: _____

Witness: _____ Chart Number: _____

If a personal representative on behalf of an individual has signed this authorization, his/her authority to act on behalf of the individual must be presented for the record, including transfer of guardian authorization.

(VALID FOR ONE YEAR FROM DATE ABOVE)

FINANCIAL POLICY

WE WOULD LIKE TO FAMILIARIZE YOU WITH HOW OUR SERVICES ARE BILLED AND INFORM YOU OF OUR FINANCIAL POLICIES. BECAUSE WE DO NOT WANT ANY MISUNDERSTANDINGS, WE ASK THAT YOU PLEASE READ OUR POLICY THOROUGHLY.

If you have any questions at all, please ask our staff, who will be happy to discuss them with you.

REGISTRATION

All new patients must complete our Patient Data sheet, Comprehensive History & Physical Form, Authorization for Release of Medical Records, as well as Authorization for Treatment, and provide a photo ID. All medical records will be obtained before you can be seen by Dr. Patterson or his staff. **Please be sure to include your email address.**

PAYMENT

As a friendly reminder, all Co-Pays/Co-Insurance & Deductibles are expected in full at the time of your visit. We accept cash, checks, Visa, Mastercard, American Express, Discover, and Care Credit. We do not accept post-dated checks and we must have signed authorization for any credit cards accepted over the phone.

INSURANCE

Please note that we participate with Medicare, Medcost, First Carolina Care, CIGNA, and most BC/BS plans. We will be happy to file your insurance for your visits with us, as a service to you, in appreciation for your paying your co-pays or your bill in full at the time service is received if we do not participate with your insurance company. Co-pays and payment are expected in full at the time service is received.*

If there is a need to re-file, primary or secondary claims, or appeal your claims, we will be happy to help with that as well, but due to the time involved for this service, we must make a charge. We have a staff of insurance claims specialist who are trained to help you with these filings, and in gaining your reimbursements from your insurance companies. Feel free to ask our staff about the charges for this special service.

We no longer provide courtesy discounts as it is in direct violation with our insurance contracts and several statutes. We understand this may impact you financially and we have many payment plans and methods available to assist you in meeting your financial obligation. We're sorry we had to change this policy; however, federal regulations and our compliance plan make it impossible to continue discounting services.

*The normal filing fees apply for any account not paid in full at the time services are rendered. For questions concerning your insurance or billing, please call us.

BILLING

Insurance Cards. So we can better serve you and file your insurance as mentioned above, please be prepared to present your insurance card each and every time you visit our office (even if we have already copied it). It is extremely important for you to notify us of any changes in your insurance coverage so we can accurately file your insurance for you and expedite your reimbursement.

BC/BS, Medcost, First Carolina Care, CIGNA & Medicare Co-pays, Co-insurance & Deductibles. The front desk will ask that you pay your deductibles, co-insurance (i.e. Patient's responsible part 80/20), and co-pays for Medicare, BC/BS, First Carolina Care, CIGNA & Medcost because all co-pays, co-insurance & deductibles are your responsibility— as are certain procedures/items not covered by Medicare, BC/BS, First Carolina Care, CIGNA & Medcost.

Changes & Pre-Authorization. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. It is your responsibility to understand the coverage your insurance program provides and its referral authorization process. It is also your responsibility to secure appropriate authorization if your plan requires prior approval to make an appointment with a specialist or to have a procedure performed, or to receive certain medications. Again we can help with this for a nominal charge.

Nonpayment of Claims. Please understand that our office cannot accept responsibility for payment or nonpayment by your insurance company, nor can we negotiate a settlement on a disputed claim on your behalf. Questions about coverage and benefits are between you and your insurer. We will do our best to help you in any way we can by providing you with the information that you may need. We believe this is another reason why it is so very important that you read your insurance policy so that you are aware of exactly what your coverage's are. This is a policy that has either been offered to you or perhaps you agreed to and purchased. In either case, you should become familiar with exactly what coverage's and

Continued on other side. SIGNATURE NEEDED →

benefits you have.

As a courtesy and service to you, we will file insurance for you, or we can provide you with an encounter form at each visit which will have all the information necessary for you to file with your insurance company. We want to remind you that payment is expected in full at the time service is rendered– **There are no exceptions unless prior arrangements have been made.**

Only under special circumstance, and only with prior credit approval, will we offer an extended payment plan.

Usual and Customary Fees. The Family Doc is committed to providing you with the best treatment and care, therefore we charge what we feel is usual, customary and reasonable for our area. Our charges are based on the complexity of your problems and the amount of time it takes to care for you and your medical needs. You are responsible for payment regardless of any insurance company’s arbitrary determination of what they may consider a different “usual and customary rate or fee.” (If we are not a participating provider)

Filling out Accident & Disability Insurance Forms. We will be glad to fill out insurance forms “for accidents and disability, etc.,” however; there is a **\$50.00** additional charge if the office staff completes the forms and **\$100.00** if a Provider completes them. This amount is to be paid at the time the form is taken. Before we can accept the form, your portion must be filled out in its entirety. We will then mail it directly to the insurance company. **Because we are held liable for the information contained on our portion, we cannot return these completed forms back to you after they are completed.** They must be mailed directly to your insurance company or employer as requested on the forms. You may receive a copy. Accident cases in Litigation will need to have prior approval before each visit. Worker’s Compensation services will need to have prior approval by the responsible company before services are rendered.

Please make sure that you provide us with any envelopes which are available and that you provide the proper mailing address.

Returned Check Charges. There is a \$25.00 fee for all returned checks. After two returned checks you will be required to pay either with cash, cashier’s check, or credit card.

Missed Appointments. Your appointment time is reserved for you. Please give our office at least 24 hours notice if you must cancel an appointment so that someone else may be given this time. If not, you will be charged **\$50.00** for routine appointments and **\$100.00** for complete physicals or other extended time visits. **Except in cases of unpredictable emergencies, you will be charged for a missed appointment.** Missed appointments are not reimbursed by insurance companies or Medicare and therefore will be your responsibility for payment of the full appointment fee. Please call our office if you are unable to keep your appointment. You can call during normal business hours and ask to speak to the appointment secretary. After hours, when given the options on the phone, push #2, which will allow you to leave a message for the appointment secretary.

Minor patients and separation/divorce policy. In separated or divorced families, the person who initiates services for the child or the teen is the party held responsible for payment. Shared financial arrangements between divorced parents need to be worked out before appointments. Also, adolescent patients who drive themselves to the office should be provided with payment from the parents for each office visit as well as written permission to treat your minor child.

Late Fee. A late fee/billing fee of **\$20.00** per month will be assessed against any outstanding balance.

Phone & E-mail communication. If you need to talk with any of us, please feel free to call and leave a message in our voice mailboxes. Please supply us with correct phone numbers and times during the day when you will be available. We will try to return your call as soon as possible. Phone calls to our providers will be forwarded to their clinical assistants where they will try to get back to you at their earliest availability. Also messages left for the on-call provider will be returned to you as early as possible. **After hours phone calls for the purpose of problem-solving, information exchange, changing of medications, refills on medications, or other therapy will be charged to your account. Phone/E-mail consultation fees and prescriptions called in without an appointment will be billed and due immediately.**

A voluntary surcharge of \$5.00 is being added to each visit to pay for liability insurance effective 1/1/07.

Patient Signature

Date

Witness Signature

Date

NOTICE OF PRIVACY PRACTICES

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.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 6/3/2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practice, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Robert Wm Patterson.

Treatment. We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations. We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Research. We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

As Required by Law. We will disclose your health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Business Associates. We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

Worker's Compensation. We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect,

USES AND DISCLOSURES OF HEALTH INFORMATION (CONT.)

or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Coroners, Medical Examiners, & Funeral Directors. We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

PATIENT RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.

Restriction: you have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: you have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (you must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

USES AND DISCLOSURES OF HEALTH INFORMATION

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complain with the U.S. Department of Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CHANGES TO THIS NOTICE. We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Robert Wm Patterson.

Contact: Robert Wm Patterson, The Family Doc Diagnostic & Wellness Center

Telephone: (919)776-3750

Address: 1411 Greenway Court
Sanford, NC 27330



The Family Doc Diagnostic & Wellness Center

1411 Greenway Court • Sanford, NC 27330
(919) 776-3750

NEW PATIENT INFORMATION SHEET
WELCOME TO OUR PRACTICE!

Please help us serve you better by taking a few minutes to provide the following information.

PATIENT INFORMATION

LAST NAME		FIRST NAME		MI	TITLE	SOCIAL SECURITY NUMBER		ACCOUNT#
STREET ADDRESS (ROAD OR STREET)					(APARTMENT# OR SECOND ADDRESS LINE)			
ZIP CODE		CITY			STATE			
HOME PHONE			MOBILE OR CELL PHONE			DRIVER'S LICENSE #		
BIRTHDAY		SEX (M,F)	RACE		E-MAIL ADDRESS			
MARITAL <input type="checkbox"/> M-Married <input type="checkbox"/> W-Widowed <input type="checkbox"/> S-Single <input type="checkbox"/> D-Divorced <input type="checkbox"/> X-Separated		EMPLOYMENT <input type="checkbox"/> R-Retired <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None		STUDENT <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None		REL. TO INSURED <input type="checkbox"/> SE-Self <input type="checkbox"/> SP-Spouse <input type="checkbox"/> CH-Child <input type="checkbox"/> OT-Other		
Who Referred you to The Family Doc? 1) DOCTOR: NAME _____ 2) FRIEND/ FAMILY: NAME _____					EMPLOYER/SCHOOL NAME			
STREET ADDRESS (ROAD OR STREET)					(APARTMENT# OR SECOND ADDRESS LINE)			
ZIP CODE		CITY			STATE		BUSINESS PHONE	

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

LAST NAME		FIRST NAME		MI	TITLE	SOCIAL SECURITY NUMBER		ACCOUNT #
STREET ADDRESS (ROAD OR STREET)					(APARTMENT# OR SECOND ADDRESS LINE)			
ZIP CODE		CITY			STATE			
HOME PHONE					PATIENT DATA (OFFICE USE ONLY)			
BIRTHDAY		SEX (M,F)	RACE		PRIMARY DOCTOR (OFFICE USE ONLY)			
MARITAL <input type="checkbox"/> M-Married <input type="checkbox"/> W-Widowed <input type="checkbox"/> S-Single <input type="checkbox"/> D-Divorced <input type="checkbox"/> X-Separated		EMPLOYMENT <input type="checkbox"/> R-Retired <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None		STUDENT <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None		REL. TO INSURED <input type="checkbox"/> SE-Self <input type="checkbox"/> SP-Spouse <input type="checkbox"/> CH-Child <input type="checkbox"/> OT-Other		
EMPLOYER CODE (OFFICE USE ONLY)			EMPLOYER/SCHOOL NAME					
STREET ADDRESS (ROAD OR STREET)					(APARTMENT# OR SECOND ADDRESS LINE)			
ZIP CODE		CITY			STATE		BUSINESS PHONE	
ACCOUNT DATA #1		ACCOUNT DATA #2		BILLING CYCLE		LOCATION	ACCOUNT CONTROL	

PRIMARY INSURANCE COMPANY NAME			MAILING ADDRESS			ATTENTION		
TELEPHONE #		POLICY #		GROUP #		EXP. DATE		
SECONDARY INSURANCE COMPANY NAME			MAILING ADDRESS			ATTENTION		
TELEPHONE #		POLICY #		GROUP #		EXP. DATE		

I authorize the release of any medical information necessary to process insurance claims.				I authorize payment of medical benefits directly to this practice for the services rendered.			
Signed		Date		Signed		Date	

HISTORY & PHYSICAL

DATE:



NAME

M	MARITAL STATUS			
F	S	M	W	SEP

DATE OF BIRTH

ADDRESS

PHONE (H)

(O)

OCCUPATION

INSURANCE

REVIEW OF SYMPTOMS Check (✓) if you have recently experienced any of the following symptoms

General: Feeling Well Weight Gain Weight Loss Appetite Loss Chills Dietary Changes Fatigue Fever Night Sweats

Skin: Bruising Change in Wart/Mole Dryness Excessive Sweating Hair Growth Hair Loss Hives Itching Rash

HEENT: Blurred Vision Headache Head Injury Color Blindness Double Vision Excessive Tearing Hearing Loss

Neck: Neck Mass Neck Pain Neck Stiffness Swollen Glands *Respiratory:* Cough Difficulty Breathing Wheezing

Breast: Breast Mass Breast Pain Nipple Discharge *Cardiovascular:* Chest Pain Irregular Heart Beat Abnormal Blood Pressure

Gastrointestinal: Excessive Gas Hemorrhoids Bloody Stool Constipation Diarrhea Heartburn Indigestion Nausea

Female: Vaginal Itching/Burning Absence of Menstruation Discharge Excessive Menstrual Bleeding Abnormal Pregnancies

Male: Hernia Discharge Sores Testicular Pain Unexplained Masses Erectile Dysfunction Iching/Burning

Musculoskeletal: Leg Cramps Back Pain Joint Pain Joint Stiffness *Neurological:* Numbness Decreased Memory Vertigo

Psychiatric: Anxiety Depression Insomnia *Endocrine:* Excessive Urination Hot Flashes Sexual Disfunction

Hematology: Abnormal Bleeding Anemia Easy Bruising *Pain:* Currently in Pain (on Scale of 0-10) _____

Any Other Symptoms:

FAMILY HISTORY If any Blood Relative has suffered any of the following, please circle the number & indicate which relative.

- | | | | |
|-----------------|--------------------|-----------------------------|--------------------|
| 1) Epilepsy | 6) Hay Fever | 11) Arthritis | 16) Hepatitis |
| 2) Migraine | 7) Asthma | 12) Heart Disease | 17) Cancer |
| 3) Glaucoma | 8) Anemia | 13) Drug/Alcohol Dependence | 18) Depression |
| 4) Diabetes | 9) Hypertension | 14) Bleeding Disorder | 19) Stroke |
| 5) Osteoporosis | 10) Lipid Disorder | 15) Thyroid Disorder | 20) Mental Illness |

HOSPITAL / ER ADMISSIONS

not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING	ALLERGIES	VACCINE	YEAR OF LAST	TEST/EXAM	YEAR OF LAST
		Tetanus / TD	_____	Eye	_____
		Influenza	_____	Dental	_____
		Pneumonia	_____	Mammogram	_____
		Hepatitis	_____	Pap Smear	_____
		Tuberculosis	_____	Colonoscopy	_____
				PSA	_____

COMMENTS/ SYNOPSIS

LIST ALL SUPPLEMENTS YOU ARE NOW TAKING