**PATIENT INFORMATION FORMS**

Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Nickname**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Primary Care Physician**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Referred By**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Social Security **# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth **\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**

Age**\_\_\_\_\_\_\_** Sex: M FMarital Status**\_\_\_\_\_\_\_\_\_** Preferred Language**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Home **#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Cell **#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Work **#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Mailing Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** State**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Zip**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Email **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Pharmacy Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Occupation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Employer**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Driver’s License**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Spouse / Next of Kin Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone **#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Race: (Circle One) Ethnicity: (Circle One)**

Caucasian / White Hispanic Hispanic

American Indian Asian Non-Hispanic

African American Native Hawaiian

**RESPONSIBLE PARTY ON INSURANCE (IF APPLICABLE)**

Subscriber on Insurance (Name) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Birth**\_\_\_\_/\_\_\_\_/\_\_\_\_\_**

Subscriber’s Social Security **#\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_** Relationship to Patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

Medicare **#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Medicaid/AHCCCS **#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Medicaid Plan (Circle One): Healthchoice APIPA Phoenix Health Plan

**PRIVATE INSURANCE INFORMATION**

Company Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ID **#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Group **#\_\_\_\_\_\_\_\_**

I understand that payment for services rendered is due at the time of service, unless previous arrangements have been made. I authorize the provider to release any information needed for the payment. I further permit copies of this authorization to be used in place of its original. I give consent for the communication of care and /or medications with my pharmacy. **IT IS THE PATIENT’S RESPONSIBILITY TO KNOW THE PROVISIONS OF THEIR INSURANCE POLICY.**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Acknowledgement of Notice of Privacy Practices**

Southwest Surgery, LLC reserves the right to modify the privacy practices outlined in the notice.

**□ I have received a copy of the notice of privacy practices for Southwest Surgery, LLC**

**Name of Patient (Print)**

**Signature of Patient Date**

**Signature of Patient Representative Relationship**

**(Required if the Patient is a minor or an adult who is unable to sign this form)**

**LEAVING VOICE MESSAGES:**

**If I am unable to be reached for any reason with regards to future appointments and/or procedures, I authorize Southwest Surgery, LLC and affiliated staff members to leave messages on my voicemail and / or answering machine.**

**Signature of Patient**

**□** I do **NOT** authorize Southwest Surgery, LLC and affiliated staff members to leave messages on my voicemail and/or answering machine.

**RELEASE OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Southwest Surgery to release any health information to the following:

**Name**

**□** Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

***Important Office Policies***

Please read the following important office policies. You are responsible for understanding these policies. If you are a minor, your parent or legal guardian must agree to these terms and sign.

**Insurance and/or payment protection forms:** You may be charged a fee of $25.00 per form, for filling out additional forms from various companies that are above and beyond the usual and customary disability form.

**Financial Responsibility:** I understand and agree that I am financially responsible for all services rendered by this office and its employees. If my account is not paid in full within 90 days, my account may be sent to collections.

**Insurance Coverage:** This office works with several different insurance companies that carry several different types of coverage-which change constantly for a variety of reasons. As a result, I understand and agree that I am solely responsible for knowing which types of services are covered under my policy or not covered on my policy.

**Insurance Billing:** We will bill all primary and secondary insurance companies as a courtesy. We ***do not*** bill third party insurances. Your insurance plan is a contract between you and your insurance. Ultimately, the patient is responsible for any account balances past 90-days.

**Co-payments:** This is the % that is the patients balance. I understand that I am responsible for knowing if my insurance plan has a co-payment, and if applicable, how much it is. The co-payment is ***due at the time services are rendered***. If for some reason the co-payment is not paid at the time of service, I am still responsible for the co-payment and will be billed for it in addition to any other charges that may be due.

**Cash Pay Patients:** Full payment is due at the time of treatment. We accept cash, checks, Mastercard, and Visa.

**AHCCCS Patients:** If I intend to have any portion of my medical care paid for by the AHCCCS program, I understand that this office will require a completed referral form from my Primary Care Physician for most types of office visits. I understand I will not be seen without an authorization form. AHCCCS patients are now required to pay a $5.00 co-pay for each visit per AHCCCS guidelines.

**Non-Sufficient Funds:** In the event that I pay for services by check and that check is returned because of non-sufficient funds, I understand that I will be billed for the charges again. In addition, a ***twenty-five dollar non-sufficient funds fee*** will be applied to compensate the office for expenses it incurs as a result.

**Discounts:** We are unable to offer discounts to any patient, due to the fact it discriminates against insurance companies and other patients who do have insurance.

**Collection Service:** In the event that my account is sent to collections for outstanding debts of ninety days or over, I understand that an ***additional fee of twenty- percent (20%)*** will be added to the amount sent to collections, and will be due and payable immediately upon imposition. I also understand that I will be responsible for any attorney fees & all cost of collections.

**Appointment Order & Rescheduling of Late Arrivals:** I understand that the office has more than one medical practitioner, and it is possible that someone who arrives after me may be seen first because of the practitioners’ different schedules. If I arrive late for my appointment, I accept that my appointment may have to be rescheduled.

By my signature below, I hereby agree to the preceding important office policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Name Parent/Legal Guardian Signature

**CANCELLATION AND NO SHOW POLICY**

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hour notice, we are unable to offer that slot to other people.

Office appointments which are canceled with less than 24 hours notification may be subject to $25.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show three (3) or more times in a 12 month period, may be dismissed from the practice and thus they will be denied any future appointments. Patient may also be subject to a $25.00 fee for office appointment NO SHOW fee.

This Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient’s next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

We believe that a good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (928-854-6500 Ext. 27).

Please sign that you have read, understand and agree to this Cancellation and No-Show policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Please Print) Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Patient Representative Date

**Stark Law**

Physician Disclosure Statement

Under the “Stark Law”, all physicians who invest in a hospital must provide a written disclosure of his or her ownership or investment interest in the hospital to all patients who the physician refers to the hospital.

**Please Note:** Over 92% of Havasu Regional Medical Center is owned by Lifepoint Health, TN.

Physician Investors

Havasu Regional Medical Center, LLC

Pareed Aliyar, MD William Binder, MD

Hitendra Chauhan, MD Devin Cunning, MD

Terrence Gleason, MD Warren Hankins, MD

Daniel Heiner, MD Gene Kalin, MD

M.A. Kazmi, MD Harrison McDonald, MD

Paul O’Neill, MD Angelo Ong-Veloso, MD

Mandeep Powar, MD Michael Prater, MD

Nick Rizos, MD A. Nicholas Rizzo, MD

Abedon Saiz, MD Bobby Shaw, MD

Thomas Wrona, MD Alexander Zilberman, MD

\*\*Investing names are subject to changed based on physician participation

**SOUTHWEST SURGERY PATIENT QUESTIONNAIRE**

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

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_

Reason for your visit today \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY (Circle all that apply):**

Diabetes High Blood Pressure High Cholesterol Thyroid Disease

COPD (Emphysema) Asthma Heart Disease Atrial Fibrillation

Strokes Peripheral Arterial Disease Headaches Rheumatoid Arthritis

Enlarged Prostate (BPH) Kidney Cancer Kidney Stones Bladder Cancer

Breast Cancer Colon Cancer Diverticulitis Pancreatitis

Intestinal Obstruction Acid reflux Glaucoma Hepatitis

HIV (AIDS) Melanoma Blood Clots

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIOR SURGERIES** **□** Please check box if you have had no previous surgeries

Previous Surgical Procedures: When:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had a COLONOSCOPY in the past? (CIRCLE) YES or NO If yes – When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST ALL CURRENT MEDICATIONS (**Including aspirin and over the counter medications)

MEDICATION DOSAGE (How much, how often?)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES: Are you allergic to any MEDICATIONS? (CIRCLE) YES or NO

NAME OF MEDICATION: TYPE OF REACTION:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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ARE YOU ALLERGIC TO ANYTHING ELSE? (CIRCLE) YES or NO

EXPLAIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THERE ANYTHING ELSE YOU FEEL THAT YOUR PHYSICIAN/SURGEON SHOULD KNOW?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT YOUR NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

IF NOT PATIENT, RELATIONSHIP TO PATIENT (PARENT, GUARDIAN, ETC.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Constitutional**

Have you had recent weight loss (> 10 lbs.)? [] Yes [] No

Have you had recent fevers? [] Yes [] No

Are you fatigue/extremely tired? [] Yes [] No

Do you have night sweats? [] Yes [] No

Have you had recent weight gain (> 10 lbs.)? [] Yes [] No

**Head and Neck**

Do you have sleep apnea? [] Yes [] No

Do you have hay fever/seasonal allergy? [] Yes [] No

Has there been any changes in your voice? [] Yes [] No

**Cardiovascular**

Do you have a history of heart murmur? [] Yes [] No

Any unusual chest pain w/ exertion? [] Yes [] No

Do you have any leg or foot swelling? [] Yes [] No

Do you have a history of heart disease/heart attack? [] Yes [] No

Do you suffer from pain in legs when you walk? [] Yes [] No

Do you have palpitations or abnormal heart rhythm? [] Yes [] No

Do you have a pacemaker? [] Yes [] No

Do you have artificial heart valves? [] Yes [] No

**Respiratory/Pulmonary**

Do you have a persistent cough? [] Yes [] No

Do you have any shortness of breath? [] Yes [] No

Do you have asthma? [] Yes [] No

Do you have a history of tuberculosis? [] Yes [] No

Have you recently coughed up blood? [] Yes [] No

Do you have a history of valley fever? [] Yes [] No

**Hematology**

Do you have any blood disease or bleeding disorders? [] Yes [] No

Do you have unusual bleeding (bruise easily)? [] Yes [] No

Do you have blood clots (legs or lungs)? [] Yes [] No

Could you have HIV or AIDS? [] Yes [] No

Do you take a blood thinner (Coumadin/Aspirin/Plavix)? [] Yes [] No

**Gastro Intestinal**

Do you have blood in stool? [] Yes [] No

Any recent Diarrhea? [] Yes [] No

Any recent constipation? [] Yes [] No

Any nausea or vomiting? [] Yes [] No

Do you have difficulty swallowing? [] Yes [] No

Do you have severe frequent heartburn? [] Yes [] No

Have you had recent loss of appetite? [] Yes [] No

**Gastro Intestinal**

History of liver disease (cirrhosis or hepatitis) [] Yes [] No

History of diverticulitis? [] Yes [] No

History of jaundice? [] Yes [] No

Do you have a history of stomach ulcers? [] Yes [] No

Any stool incontinence (stool leaking)? [] Yes [] No

Have you ever had an upper endoscopy (stomach)? [] Yes [] No

Have you ever had a colonoscopy? [] Yes [] No

**Neurologic**

Do you have unusual headaches? [] Yes [] No

Do you have seizures? [] Yes [] No

History of stroke or stroke symptoms (TIA)? [] Yes [] No

Do you suffer from fainting spells? [] Yes [] No

**Muscular Skeletal**

Do you have joint problems? [] Yes [] No

Do you have a history of gout? [] Yes [] No

Do you have a history a back problems/sciatica? [] Yes [] No

**Psychiatric**

Do you suffer from depression? [] Yes [] No

Any history of eating disorders? [] Yes [] No

Do you suffer from anxiety? [] Yes [] No

Psychiatric problems? [] Yes [] No

**Genito-Urinary**

Any history of kidney stones? [] Yes [] No

Any history of kidney disease? [] Yes [] No

Do you suffer from frequent kidney infections? [] Yes [] No

Have you had any recent blood in urine? [] Yes [] No

Do you have any urine incontinence (leaking)? [] Yes [] No

Do you have painful urination (peeing)? [] Yes [] No

**For Females Only**

Do you have any nipple discharge [] Yes [] No

Have you gone through menopause? [] Yes [] No

Are you pregnant? [] Yes [] No

Have you had a mammogram in the last two years? [] Yes [] No

**For Males Only**

Do you have difficulty urinating (peeing)? [] Yes [] No

Do you suffer from impotence? [] Yes [] No

Do you awake at night to urinate (pee) more than twice? [] Yes [] No

Do you have problems with your prostate? [] Yes [] No

**Family History** (Check all that apply)

**Mother**: O Diabetes O Heart Disease O High Blood Pressure O Blood Disease O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Father**: O Diabetes O Heart Disease O High Blood Pressure O Blood Disease O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Brother**: O Diabetes O Heart Disease O High Blood Pressure O Blood Disease O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sister**: O Diabetes O Heart Disease O High Blood Pressure O Blood Disease O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Maternal Grandfather**:

O Diabetes O Heart Disease O High Blood Pressure O Blood Disease

O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Maternal Grandmother**:

O Diabetes O Heart Disease O High Blood Pressure O Blood Disease

O Kidney Disease O Thyroid Disease O Cancer (Type of Cancer):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Occupation: O Employed O Retired O Unemployed O Disabled

Marital Status: O Single O Married O Divorced O Widow O Life Partner

Do you smoke: O Yes O No O Quit O Never

How often do you drink alcohol: O Occasionally O Daily O Never

Do you use recreational drugs: O Yes-occasionally O Yes-frequently O No-Never