ST. MARY'S MEDICAL GROUP

Patient Registration Forms **Please Fill out Completely**

Date:	Are you a patient of any other St. Mary's Medical Group location? YES NO If yes, what other locations?	Name of Physician you are scheduled to see

Patient's Last Name	First Name	MI

Social Security Number	Date of Birth	Age	Gender	Race	Marital Status	Ethnicity (Circle one): Latino Non-Latino Other	Language

Address (Street, Route, Apt. No., etc.)	City	State	Zip Code

Home Phone	Cell Number	Cell phone carrier (ex. Verizon)

Email Address	Do any other family members use this email address? List names	Best way to contact: ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Letter

EMPLOYER INFORMATION

Employed by	Occupation

Business Phone	Employer's Address	City	State	Zip Code

SPOUSE/GUARDIAN (If patient is married, give spouse information. If patient is a child, give parent information.)

Name	Relationship to patient	Responsible for bill: YES NO

Home Phone	Social Security	Date of Birth	Sex

Employed by	Business Phone

Employer's Address	City	State	Zip Code

EMERGENCY CONTACT

Name	Relationship	Home Phone	Work Phone	Mobile Phone

PHYSICIAN INFORMATION

Complete this section only if applicable

Primary Care Physician Name	Phone		

Address	City	State	Zip Code

Referring Physician Name	Phone		

Address	City	State	Zip Code

INSURANCE INFORMATION **(Please provide your insurance card(s) at the time of visit)**

Primary Insurance Name	Subscriber Name	Date of Birth	Social Security #	Relationship to patient	Responsible for bill: YES NO

Secondary Insurance Name	Subscriber Name	Date of Birth	Social Security #	Relationship to patient	Responsible for bill: YES NO

_____ _____

Patient or Guardian Signature Date

ST. MARY'S MEDICAL GROUP

CONSENT AND AUTHORIZATION

DEFINITIONS

"St. Mary's" means St. Mary's Medical Group, Inc., St. Mary's Health Care System, Inc., and its affiliates. "I" or "me" or "my" means the undersigned patient or the undersigned authorized representative on behalf of the patient. "Insurance" means any policy, plan, product, network, employer benefit or plan, self-insured program, or government program or assistance applicable to the patient.

CONSENT TO TREATMENT

I authorize and consent to such assessment, care, examination and treatment (including, but not limited to, any medications, laboratory tests, imaging studies, diagnostic or other procedures, services and supplies) as St. Mary's physicians or providers may determine in their judgment to be necessary, appropriate or desirable for me (my "Care"). I understand that this consent will continue in effect unless and until I revoke it and will apply to each of my visits to any St. Mary's provider as well as to any Care which may be needed but which is not known at the time this consent is signed.

INFORMATION

I have or will provide accurate and complete information regarding my medical history including any allergies, medications, supplements, herbs and current and pre-existing conditions; and, I understand that St. Mary's and its employees, agents, staff, representatives, and contractors will rely on such information in determining and recommending the Care to be provided to me. In addition, any information I have provided regarding my eligibility for Insurance is true, accurate and complete.

STUDENTS & RESIDENTS

I understand that students, residents, interns, and fellows may from time to time be present and either observe or participate, under supervision, in my Care and I consent to their involvement in my Care.

RISKS

I understand that it is not possible to list each and every risk for every type of health care service which may occur with my Care and that there may be material risks associated with Care that will be provided to me. An additional consent form will be given to me for specific procedures such as those which involve certain types of anesthesia, amniocentesis, or injection of a contrast (dye) material. **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** or otherwise implied regarding the results of my Care.

FINANCIAL AGREEMENT

I understand that I am financially responsible for and obligated to pay all St. Mary's charges incurred in connection with my Care. At the time services for my Care are rendered, I will pay any applicable copayment, deductible, coinsurance, or other amount not covered by my Insurance at the time services are rendered or I will make financial arrangements satisfactory to St. Mary's for such payment. If I am uninsured or am having difficulty paying my bill(s), I understand that St. Mary's has other financial options that may be of assistance to me including free care, discounted care, and interest free payment plans, and that I should contact the St. Mary's Business Office to learn more. As permitted by the Fair Credit Reporting Act, I authorize St. Mary's to check my credit history in connection with payment for my Care. If any of my accounts is sent to collections, I agree to pay all collection expenses including attorneys' fees and court costs.

I understand some health care professionals who render Care to me may not be participating members in my Insurance and that my insurer may therefore consider such services to be non-covered. If my insurer does not reimburse for these non-participating health care professionals or non-covered services, I understand I will be responsible for any charges/balance that the insurer declines to pay.

I understand I have the option to pay for a health care service personally and not have a claim submitted to a health plan for that health care service; *however, to elect this option, I must notify the St. Mary's Business Office and must pay the bill for that health care service in full.*

ASSIGNMENT OF BENEFITS & REQUEST FOR DIRECT PAYMENT

In consideration of St. Mary's advancing or extending credit to me for the charges related to my Care, I assign and transfer to St. Mary's all rights to (and related or associated with) any and all benefits, claims and/or payments now due and payable (or to become due and payable) as reimbursement or payment for my Care under any applicable Insurance, settlement, or judgment arising out of or related to any incident which necessitated the Care, or any authorized Medicare, Medicaid, TriCare, or any other governmental benefits that may be applicable for my Care. The rights so assigned include, but are not limited to, the right to receive payment, to receive information from plans, payors or insurers as may be appropriate to determine payable benefits, and to bring claims/causes of action or file appeals on my behalf in order to obtain payment. This assignment also specifically includes the right to enforce a claim for benefits, sue for statutory penalties, assert an ERISA claim as a beneficiary of an employee benefit plan, and pursue an ERISA breach of fiduciary duty claim.

I authorize and direct that payment be made on my behalf directly to St. Mary's for my Care whether now or in the future. I authorize St. Mary's to bill my Insurance and I will use my best efforts to cooperate with and assist St. Mary's in receiving payment in full for the Care rendered to me including remitting to St. Mary's any payments I receive directly from an insurer or any source whatsoever for Care provided to me. I appoint St. Mary's Chief Financial Officer or his/her designee as my attorney-in-fact to take measures to collect the above payments and benefits and to endorse any checks payable to me related to my Care.

RELEASE OF MEDICAL INFORMATION

I authorize St. Mary's and its business associates, agents, employees, staff, representatives and contractors to release any medical or other information relating to my Care as permitted by the Health Insurance Portability and Accountability Act (HIPAA) including for payment, treatment, and healthcare operation purposes. This authorization includes information which may be protected under State law such as HIV, AIDS, mental health, substance abuse, infectious or communicable diseases, and confidential communications. I also authorize release of such information to the Social Security Administration, the Centers for Medicare and Medicaid Services, and the Department of Medical Assistance (or any of their respective intermediaries, carriers, contractors or fiscal agents), or to any review organizations, for any claim or purpose relating to my Care.

I agree my information can be shared with other past, future and current providers and facilities to coordinate my health care and for payment and administrative purposes, including quality and care management. This information may include dates and services provided, location where treatment was received, treatment information, names of doctors and health professionals, including mental health professionals, and any information related to diagnosis, hospital care, treatment, or my mental or emotional condition, except substance abuse treatment provided in a federal Part 2 substance abuse unit. I also consent to St. Mary's requesting my health information from other providers of care to me, receiving and releasing that health information, whether written, verbal, or electronic, for the uses described above as well as St. Mary's participating in the health information exchange described in the St. Mary's Notice of Privacy Practices (NPP). I acknowledge I have received the NPP and will refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

DISPOSAL

Any tissues or specimens removed from my body in the course of any Care may be retained by, preserved, tested and/or otherwise used by St. Mary's and its affiliates, agents, employees, staff, representatives and contractors for diagnostic, treatment, scientific and/or teaching purposes and then disposed of within their discretion and professional judgment.

INDEPENDENT CONTRACTORS

Some health care professionals performing services for St. Mary's are independent contractors and are not St. Mary's agents or employees. Independent contractors are responsible for their own actions and St. Mary's is not liable for the acts or omissions of any such independent contractors.

PHONE/E-MAIL

St. Mary's, including its business associates, may contact me by telephone at any telephone number provided by me or associated with my record, including cell phone numbers which could result in charges to me. St. Mary's may also contact me by sending text messages or e-mails using the contact information I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. By providing an e-mail address to St. Mary's, I request and consent that St. Mary's, its affiliates, agents, employees, staff, representatives and contractors use the e-mail address that I provide in addition to or in place of using U.S. Mail, fax or any other method of delivery for corresponding with me or providing me notices, reminders and other information regarding my Care, even if the communication includes my personal or health information, as applicable. I consent that emails may include communications about St. Mary's programs and services, the online Patient Portal, and fundraising for a St. Mary's affiliated foundation. I understand St. Mary's does not receive remuneration for making these communications. I may revoke this consent by contacting the St. Mary's Privacy Officer in writing, but my revocation will not be effective regarding any use or disclosure by email in reliance on this consent before St. Mary's actually receives my revocation. I acknowledge there are some risks involved in sending and receiving electronic communications including that the communications may not be encrypted and might be sent to unintended recipients. I understand I am responsible for the security of my email password. I understand not all email is necessarily confidential and I should use another method to communicate sensitive and/or urgent information.

CONSENT TO PHOTOGRAPH, VIDEOTAPE, RECORD, FILM AND AUDIOTAPE

I consent to the presence of observers during my Care as approved by my physician or St. Mary's for medical, training, scientific and/or educational purposes. I authorize my physician and St. Mary's as well as its governing bodies, officers, directors, staff, agents, contractors and employees to photograph, videotape, record, film, audiotape, and/or televise the Care and use such materials for their internal purposes including, but not limited to, patient identification, treatment, training, performance improvement, and/or educational purposes. I understand a separate consent form will be provided to me for external or commercial publication purposes.

I authorize a copy of this Consent & Authorization form to be used in place of the original.

I HAVE READ THIS FORM CAREFULLY OR HAD IT READ TO ME AND/OR EXPLAINED TO ME. I UNDERSTAND WHAT IT SAYS AND HAVE HAD ANY QUESTIONS I HAD ABOUT IT ANSWERED. I VOLUNTARILY SIGN IT ON THE DATE SET FORTH BELOW.

_____	_____
Patient Name (Print)	Patient Date of Birth
_____	_____
Patient or Guardian Signature	Date

ST. MARY'S MEDICAL GROUP

CONSENT FOR DISCLOSURE

I have agreed to let certain individuals participate in discussions and decisions related to my health care. I therefore give permission for the physicians, providers, and staff of St. Mary's Medical Group, Inc. (collectively, "SMMG") to discuss my personal health care information with the following individual(s):

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Conditions for Disclosure (check all that apply):

☐ SMMG may disclose my personal health information to the individual(s) above **only** in my presence.

☐ Unless indicated otherwise, SMMG may disclose my personal health information to the individual(s) above in my presence as well as when I am *not* physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

☐ Other conditions of disclosure: _____

_____

I understand that this consent may be revoked by me at any time by written notice to SMMG.

Patient Signature: _____ Date: _____

Legal Representative: _____ Date: _____

Reason for Representative: _____

Consent For Disclosure to Family Member and/or Personal Representative for St. Mary's Medical Group, Inc.

Patient Name _____
Address: _____
_____
Date of Birth: _____
SSN# _____
Telephone # _____

ST. MARY'S MEDICAL GROUP

Authorization for Release of Medical Information

I authorize the use or disclosure of the below-named patient's protected health information as described below.			
Patient Name	Date of Birth		Last 4 digits of SSN
Address	City	State	Zip

Please circle: I authorize St. Mary's Medical group to <u>OBTAIN or RELEASE</u> records from:
Name/Organization

Address	Phone	Fax

Please send records to:
Name/Organization

Address	Phone	Fax

If records are to be released from SMMG, please indicate which location. Check all that apply.

- ☐ **Athens Internal Medicine Associates**
- ☐ **Community Internal Medicine of Athens**
- ☐ **Georgia Family Medicine**
- ☐ **Johnson and Murthy Family Practice**
- ☐ **Lighthouse Family Practice**
- ☐ **Middle GA Medical Associates**
- ☐ **St. Mary's Internal Medicine Associates**
- ☐ **Hometown Pediatrics**
- ☐ **St. Mary's Family Medicine**
- ☐ **Athens General and Colorectal Surgeons**
- ☐ **Clear Creek OBGYN**
- ☐ **Endocrine Specialists of Athens**
- ☐ **Infectious Disease Specialists of Athens**
- ☐ **St. Mary's Industrial Medicine**
- ☐ **Oconee Heart & Vascular Center**
- ☐ **Northeast Cardiology**
- ☐ **Rheumatology Center of Athens**
- ☐ **St. Mary's Neurological Specialists**
- ☐ **Georgia Neurological Surgery and Comprehensive Spine**

Purpose of Release? ☐ Insurance ☐ Personal ☐ Treatment Elsewhere ☐ Transfer of Care ☐ Legal
☐ Other (please describe) _____

What type of records/reports should be released?

- ☐ Complete Record
- ☐ ER Record
- ☐ Office Notes
- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Surgical/Operative Report
- ☐ Most recent lab work
- ☐ Echo
- ☐ Nuclear Stress Test
- ☐ Exercise Stress Test
- ☐ EKG
- ☐ Carotid/Vascular Study
- ☐ Chest X-Ray
- ☐ Mammogram
- ☐ CT Scan _____
- ☐ MRI _____
- ☐ EEG
- ☐ EMG/NCS
- ☐ Other:_____

If my health record contains information about my mental health, substance abuse, HIV/AIDS diagnosis, infectious or communicable diseases, or other sensitive or confidential information, I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Office Manager; however, I understand that any revocation would not apply to information that has already been released prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign this authorization.

_____ **Date: _____/_____/_____**

Patient Signature/Legal Representative Signature

_____ _____

Printed Name of Legal Representative **Relationship to patient**

ST. MARY'S MEDICAL GROUP

eRx Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe medications electronically beginning in 2011.

ePrescribing software sends your prescriptions over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your physician see important information like drug interactions and your prescription history.

The benefit to you is:

- ✓ Less confusion over handwritten prescriptions or unclear phone calls
- ✓ Reduced possibility of medical errors
- ✓ Less chance of adverse drug reactions
- ✓ Fewer trips to drop off at the pharmacy
- ✓ A safer, faster, easier way to get your prescription filled

Patient Consent

I agree that St. Mary's Medical Group may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____	_____
Patient Signature (or legal guardian)	Printed Name of Patient
_____	_____
Primary Pharmacy Name	Pharmacy Street and City
_____	_____
Secondary Pharmacy (if applicable)	Pharmacy Street and City
_____	
Date	

ST. MARY'S MEDICAL GROUP

Medical History

Please take a few minutes to fill out our health history forms. Please fill in all areas, before your appointment. Your answers will help our providers plan for your visit and provide you the best care.

Name: _____ Date of Birth: _____ Today's Date: _____

Pharmacy: _____ Location: _____

Reason for visit/main problem: _____ Where is your problem located: _____

How long have you had this problem: _____ What makes it worse or better: _____

_____

ADVANCE DIRECTIVES: *Please check all that apply*

Do you have a Power of Attorney for health care? ☐ No ☐ Yes Designated Individual:

Do you have a living will/Do Not Resuscitate? ☐ No ☐ Yes

Are you an organ donor? ☐ No ☐ Yes

PATIENT CARE TEAM: *Please answer each question*

Specialty:	Name/Group:	Last Visit Date:	Specialty:	Name/Group:	Last Visit Date:
Cardiologist			OBGYN		
Neurologist			Eye Doctor		
Surgeon			Pulmonologist		
Dermatologist					
Gastro					

CURRENT MEDICAL HISTORY: *Please check all that apply*

☐ Addiction ☐ Anemia ☐ Anxiety ☐ Arthritis/Gout ☐ Asthma ☐ Bipolar ☐ Colon Disease ☐ Congestive Heart Failure ☐ COPD/Emphysema ☐ Dementia ☐ Depression ☐ Diabetes ☐ Enlarged Prostate ☐ Reflux/GERD ☐ Blood Clot ☐ Heart Attack	☐ Hepatitis type: _____ ☐ High Cholesterol ☐ High Blood Pressure ☐ Irritable Bowel Syndrome ☐ Kidney Disease ☐ Kidney Stones ☐ Liver Disease ☐ Migraines ☐ Osteoporosis ☐ Parkinson's Disease ☐ Pulmonary Embolism ☐ Schizophrenia ☐ Skin Disease ☐ Stroke ☐ Thyroid Disease	Are you currently under treatment/s for Cancer? ☐ No ☐ Yes Type: _____ _____ _____ Other Mental Illness: _____ _____ _____ Other Illness: _____ _____ _____ _____ _____	Have you fallen in the last 2 months? ☐ No ☐ Yes Have you fallen in the last 6 months? ☐ No ☐ Yes

HOSPITALIZATIONS/SURGERIES: *Please check all that apply*

☐ Appendectomy ☐ Coronary Artery Bypass (Open Heart) ☐ Carotid Endarterectomy ☐ Cholecystectomy (Gallbladder) ☐ Bariatric Type: _____	☐ Hysterectomy ☐ Mastectomy ☐ Nephrectomy ☐ Splenectomy ☐ Tonsillectomy/Adenoidectomy	☐ Other surgeries: _____ _____ ☐ Other Hospitalizations: _____ _____ _____

FAMILY MEDICAL HISTORY: *Please check all that apply and check all family members that apply*

Illness	Relation to you
☐ Alcoholism	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Anemia	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Asthma	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Blood Disorder	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Cancer Type: _____	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent

Illness	Relation to you
☐ Stroke	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Dementia	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Diabetes	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Heart Disease	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ High Cholesterol	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ High Blood Pressure	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Kidney Disease	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Mental Illness	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Osteoporosis	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Heart Attack <50 yrs of age	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Seizures/Epilepsy	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Thyroid Problems	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent
☐ Other: _____	☐ Mother ☐ Father ☐ Sibling ☐ Child ☐ Paternal Grandparent ☐ Maternal Grandparent

SOCIAL HISTORY: *Please check and/or answer each question.*

Tobacco Use	☐ Current Packs/day: _____ ☐ Former Year Quit: _____ ☐ Never ☐ Exposure second hand ☐ E-Cigs ☐ Smokeless ☐ Other: _____
Alcohol Use	☐ Never drink ☐ Occasional/social drinker ☐ _____# of drinks/day of alcohol
Drug Use	☐ None ☐ Other use:
Caffeine Use	☐ No ☐ Yes How Much: _____
Exercise	Regular Exercise? ☐ No ☐Yes ☐Sedentary ☐Light ☐Moderate
Seatbelt use	☐ No ☐ Yes
Marital Status	☐ Married ☐ Divorced ☐ Widowed ☐ Single # of Children: _____ # of Grandchildren: _____ Spouse's Name: _____
Living Arrangements	☐ Independent ☐ Alone ☐ With others ☐ Homeless ☐ Nursing Home ☐ Assisted Living ☐ With Caregivers
Employment	Occupation: _____ Employer: _____
Sexually Active	☐ No ☐ Yes with: ☐ Male ☐ Female ☐ Both # of sexual partners: _____
Environment exposures	☐ Fumes ☐ Dust ☐ Solvents ☐ Noise ☐ Bloodborne Pathogens ☐ Other: _____

WOMENS HEALTH HISTORY: *Check and/or answer each question.*

Age at first period: _____ yrs old	Has menopause started/occurred? ☐ No ☐ Yes at age _____ yrs
Number of days between periods: _____	Number of days period lasts: _____ Flow is: ☐ light ☐ moderate ☐ heavy
Number of: Total Pregnancies: _____	Full term births: _____ Premature births: _____ Miscarriages: _____ Abortions: _____
Number of: Vaginal births: _____ C-Section: _____	Pregnancy Complications: ☐ No ☐ Yes ☐ High BP ☐ Diabetes ☐ Pre-eclampsia ☐ other: _____

Birth Control: ☐ None ☐ Pill ☐ Depo-Provera ☐ IUD ☐ Partner-Vasectomy ☐ Tubal Ligation ☐ Other: _____

ALLERGIES: *List all allergies and the type of reaction*

Allergy	Reaction

CURRENT MEDICATIONS: *List all medications including over the counter and supplements. Please bring your medicine bottles to your appointment. Please attach a second sheet if more space is needed.*

Medicine	Dosage	Taken How often	Provider	Need Refill?
Example: Lasix	20mg	Twice a day	Dr. Smith	Yes

IMMUNIZATIONS: *Please check all that apply* ****Please bring a copy of your immunization records to your appointment****

Vaccine	Administered Date	Vaccine	Administered Date
Tetanus		Shingles	
Pneumonia		HPV	
Flu Shot		Meningitis	
Hep B		Hep A	

PREVENTIVE CARE: *Please list the dates of your last test, facility test was performed and the results if known.*

Test	Date	Facility	Results
Mammogram			
Pap Smear			
Colonoscopy			
Hemoccult			
Dexa/Bone Density			
PSA			

DEPRESSION SCREENING: *Please answer both questions.*

Over the past two weeks, I have had little interest or pleasure in doing things: ☐ No ☐ Yes

Over the past two weeks, I have felt down, depressed or hopeless: ☐ No ☐ Yes

Do you have a past history of depression? ☐ No ☐ Yes Are you currently being treated for depression? ☐ No ☐ Yes

REVIEW OF SYSTEMS: *Check all symptoms below that you are CURRENTLY experiencing.*

General
- ☐ Fever
- ☐ Chills
- ☐ Change in Appetite
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain

Eyes
- ☐ Double vision
- ☐ Blurred Vision
- ☐ Change in vision

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle aches

Dermatologic
- ☐ Suspicious lesions
- ☐ Itching
- ☐ Rash

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep problems

ENT
- ☐ Ear Pain
- ☐ Decreased Hearing
- ☐ Difficulty swallowing
- ☐ Sore throat
- ☐ Voice change
- ☐ Sinus problems

Cardiovascular
- ☐ Chest pain
- ☐ Racing/skipping beats
- ☐ Swelling (feet/legs/hands)
- ☐ Leg pain with exertion
- ☐ Varicose veins

Hematological
- ☐ Enlarged lymph nodes
- ☐ Abnormal bleeding
- ☐ Abnormal bruising
- ☐ Anemia

Allergy
- ☐ Hives
- ☐ Rash
- ☐ Seasonal allergies
- ☐ Food allergies
- ☐ Year round allergies

Respiratory
- ☐ Sleep disturbance due to breathing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Excessive snoring

Female Genitourinary
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge
- ☐ Pain with periods
- ☐ Irregular periods
- ☐ Vaginal discharge

Genitourinary
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Urinary frequency
- ☐ Urinary hesitancy
- ☐ Frequent urination at night
- ☐ Incontinence
- ☐ Decreased libido

Male Genitourinary
- ☐ Erectile dysfunction
- ☐ Testicular pain

Gastrointestinal
- ☐ Indigestion/heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Dark tarry stools
- ☐ Bloody stools

Neurological
- ☐ Difficulty concentrating
- ☐ Headaches
- ☐ Falling down
- ☐ Weakness
- ☐ Tremors
- ☐ Memory loss
- ☐ Numbness/tingling
- ☐ Lightheadedness
- ☐ Vertigo

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive urination
- ☐ Excessive thirst

Additional information you would like to share with the provider: