TOTAL
FAMILY
WELLNESS

Dear Patient,

Your appointment is scheduled for _____ at _____AM/PM

with Dr. _____.

To effectively provide the best care to our patients as a Patient-Centered Medical Home, we ask that our patients/families provide complete and accurate patient information at every visit, including current medications, visits to specialists, medical history, health status, recent test results, self-care information and data from recent hospitalizations, specialty care or ER visits.

To make the best use of your visit time, I ask that you please:

- ❒ **Complete the attached new patient packet and bring it with you at the time of your appointment.**
- ❒ **Complete the attached Authorization to Use or Disclose Protected Health Information form only if records need to be requested from another physician's office.**
- ❒ **Place all of your medication vials in a bag and bring them with you or bring a list which details the dosage and timing of each medication.**
- ❒ **Bring your current insurance card and photo ID.**
- ❒ **Notify the office staff in advance of your appointment if we can accommodate any special needs.**
- ❒ **Notify us in advance if you will be late or need to reschedule for any reason.**

I look forward to seeing you soon.

Sincerely,

TOTAL FAMILY WELLNESS **PATIENT REGISTRATION** *(please print clearly)*

****** All Fields Must Be Completed ******

PATIENT INFO

Date:_____ Social Security # :_____

First Name:_____ MI ___ Last: _____ Suffix:_____

Sex: M / F Date of Birth:_____ Age: _____

(Please circle one)

Marital Status: Single Married Divorced Widowed Legally Separated

Nationality: African Amer. Amer. Indian Asian Caucasian Hispanic Other

Ethnicity: Latino/Hispanic Other Refused

Primary Language: _____

PATIENT INFO CONT.

Patient's Permanent Address	***Employment status:(Please Circle One)***
Address:_____	EMPLOYED SELF EMPLOYED RETIRED DISABLED UNEMPLOYED STUDENT
Address:_____	
City:_____	Employer Name _____
State:_____ Zip:_____	Address: _____
Please Circle Preferred Number for Primary Communication	City:_____
Home Phone:_____	State:_____ Zip:_____
Work Phone:_____	Home Phone:_____
Cell Phone:_____	Work Phone:_____
E-mail Address:_____	Home Phone:_____
Write in NONE if no e-mail address is available	Work Phone:_____

Who is your Primary Care Doctor: _____

Who can we thank for referring you today? (Please circle one) Referral Svc Walk-In Provider Directory Friend Website

Referring Physician:_____ Self Referred Billboard Other _____

GT INFO

Financial Responsible Party or Guarantor Name: _____

DOB: _____

Address: _____ City: _____

Address: _____ State: _____ Zip: _____

INSURANCE INFO

Primary Carrier:_____	**Secondary Carrier**:_____
Subscriber:_____	Subscriber:_____
Subscriber DOB:_____	Subscriber DOB:_____
Subscriber ID #:_____	Subscriber ID #:_____

EMR CONT. INFO

Name: _____ Relationship to pt:_____

Phone: _____ Work Phone: _____ SSN:_____

EXTENDED INFORMATION

Who is the legal guardian for the patient? Please circle one: **Self** or **Other**

** If other is selected please print name and phone number*

Name:_____ Phone:_____

Smoker? Please circle one: **Current Smoker** **Former Smoker** **Never Smoked**

Do you have a visual impairment that would hinder you from reading written materials from your physician?
Please circle one: **Yes** or **No**

Do you have a hearing impairment that would impede verbal communication with your provider?
Please circle one: **Yes** or **No**

TOTAL
FAMILY
WELLNESS

_____ _____

Patient Name (printed) Date of Birth

ALTERNATIVE COMMUNICATION RELEASE FORM

I authorize Total Family Wellness, in regards to my protected health information:

____To call me at work
____To call me at home
____To call my cell phone
____To speak with anyone listed on the Right To Share Information list
____To only speak with me
____To fax information to me at this secured number_____
____Other _____
(Alternative address)
_____

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

Total Family Wellness reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends please list those individuals that we are authorized to release information.

_____ _____

Signature of Patient Date

_____ _____

Witness Date

TOTAL FAMILY WELLNESS

Financial Notice

Patient _____ **DOB**_____

Thank you for choosing Total Family Wellness as your healthcare provider. In an effort to avoid any misunderstanding, we have provided information concerning our financial policy. By signing this agreement, you confirm that you have read, understand and agree to comply with this policy.

INSURANCE

Your health insurance does not guarantee payment for medical care. Typically, payment by your health insurance is dependent on if Total Family Wellness is a contracted provider with your health insurance. Some insurance plans may pay Total Family Wellness as a non-contracted provider under out-of-network benefits, but often result in higher out-of-pocket expenses for the patient. You will be responsible for these expenses. We recommend that new patients or patients with a recent change to their health insurance contact their health insurance company to confirm that the provider you are scheduled to see participates with your health insurance. You are responsible for any balance not covered by your health insurance. Total Family Wellness reserves the right not to accept corrected information after timely filing guidelines have expired.

The medical care provided to you is based on prevailing standards of care and your best interest. The providers' determinations of care are independent of health insurance coverage. Knowing the benefits and coverage of your health insurance policy is your responsibility. Each health insurance company has their own payment determination guidelines. We will attempt to address general questions or concerns you may have regarding your health insurance; however your insurance contract is between you, your employer and the insurance company. In most cases we are not in a position to know your coverage limitations or exclusions to your policy. You should contact your health insurance company should you have questions concerning coverage or payment of your claims.

REFERRALS AND AUTHORIZATIONS

New patients whose health insurance requires a referral or prior-authorization from your physician prior to seeing a Total Family Wellness provider are responsible to obtain such referral or prior-authorization. Failure to do so may result in denied or reduced payment for services from your health insurance, which may render you responsible for additional balances. Total Family Wellness may cancel or reschedule an appointment until you have obtained the required referral or prior-authorization.

Total Family Wellness will obtain referrals or prior-authorizations for established patients; however it is ultimately your responsibility to confirm the required referral or prior authorization has been obtained. You must notify Total Family Wellness of any insurance changes at the time of check-in. Failure to do so may result in non-payment by the insurance, which may render you responsible for the entire cost of any services.

COPAYS/DEDUCTIBLES AND PAST DUE BALANCES

Cash, personal checks and all major credit cards are acceptable forms of payment. Post-dated checks will not be accepted. Please refer to your patient statement for additional payment options.

Copays, deductibles, co-insurance and any past-due balances are due at the time of services unless prior arrangement has been made with our central billing office. Your appointment may be rescheduled if your amount due is not paid at check-in.

Should financial situations arise that may prevent timely payment of your balance, you are encouraged to contact our central billing office for assistance in the management of your account balance. There are instances in which we may develop a mutually acceptable payment plan until the balance is paid in full.

For delinquent balances, Total Family Wellness reserves the right to:

- Report non-payment of copays, coinsurance and deductibles to your health insurance.
- Refer past-due balances to an outside collection agency for collection and/or to report the past-due balance to a credit reporting agency.

- Dismiss you from Total Family Wellness for non-payment.
- Patients are responsible for the original past-due balance in addition to all costs of collection, including but not limited to collection agent fees and attorney fees.

Returned Checks
A returned check will result in a service fee of $25 and may require all future payments to be made by cash or credit card.

Refunds and Credits
Refunds will be issued within 2-3 weeks of the request and only after any outstanding balances have been resolved. This includes any outstanding claims and any balance on other accounts for which you may be financially responsible (such as a child).

Divorce and Child Custody Cases
Regarding divorce, the person who receives care at Total Family Wellness is responsible for payment of copays, co-insurance, or deductibles at the time of service.
Regarding child custody, the parent who presents their child for care at Total Family Wellness is responsible for payment of copays, co-insurance, or deductible at the time of services.

CANCELLED APPOINTMENTS
Notice of 24 hours should be given if you need to cancel or reschedule an appointment. A no-show fee may be charged in the event that you do not notify the office within 24 hours.

Patient Consent

I request that payment of Medicare and/or insurance benefits be made on my behalf to Total Family Wellness for any services provided. I authorize release of any medical information necessary to determine these benefits.

I acknowledge that I will be fully responsible for any services deemed "non-covered" by my health insurance company or Medicare.

AGREEMENT OF FINANCIAL RESPONSIBILITY
I agree to be financially responsible for services provided as applicable.
Total Family Wellness agrees to file my claim to my insurance as provided. I understand that payment of services will not be delayed or withheld because of insurance discrepancies within my ability to correct (e.g. coordination of benefits, terminated coverage, etc.) I understand that services denied due to unfulfilled insurance requests will become my responsibility. Total Family Wellness agrees to file my secondary insurance plan if applicable on a courtesy basis. I understand that balances remaining unsatisfied due to nonpayment from my secondary insurance plan may become my responsibility after 60 days. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

Patient/Guardian_____ **Date**_____

Staff Member/Witness_____ **Date**_____

TOTAL FAMILY WELLNESS

Privacy Notices

Patient_____ **DOB**_____

NOTICE OF PRIVACY PRACTICES: I acknowledge I have received the notice of privacy practices.

Patient/Guardian _____ **Date** _____

Staff Member/Witness_____ **Date**_____

Reason for not obtaining Signature_____
This acknowledgement must be retained in patient's chart for 7 years from date of signature.

Medical Record Requests

At your request and with a completed authorization on file, medical records may be provided to another physician as a professional courtesy.

Our facility may choose to engage a vendor to fulfill any other medical record request. This partnership allows our clinical staff to continue to solely focus on your healthcare needs. By utilizing our selected vendor we can ensure that your protected health information (PHI) is safely and expediently transferred from our organization to the authorized requester(s). Our vendor offers HIPAA compliance, advanced technology, and heightened security measures. Their employees receive extensive HIPAA training and sign confidentiality and code of conduct agreements to remain aligned with our BayCare values. Due to the strict procedural regulations and associated costs involved in the release of PHI (Protected Health Information) you may be billed applicable copy fees (Florida rule; 64B8-10.003) should you wish to have a copy of your records for personal use. You may receive a separate invoice from them for these services.

To request records, please submit a completed authorization to your provider's office or your completed form may be faxed to Medical Records (727) 754-5910.

TOTAL
FAMILY
WELLNESS

Patient No-Show Policy and Procedure

Total Family Wellness provides standards for scheduling patient appointments that help enhance patient care. Please understand that our appointment times are scheduled to allow us to take care of each patient's individual needs during the patient's visit. To promote efficient access to our office, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance.

In the event an appointment is missed or cancelled with less than 24 hours' notice or no notice, Total Family Wellness follows the process below:

- **1st missed appointment:** We will call you and reschedule the appointment.
- **2nd missed appointment:** We will call and offer to reschedule. You will receive a letter explaining our policy, and you may be charged a missed appointment fee of up to $35.
- **3rd missed appointment:** This could result in discharge from our practice. You may be asked to find another physician outside of the Total Family Wellness group of physicians.

Our main concern is to manage your health care with the highest quality skill and efficiency we can offer. If you have questions, our staff will be happy to answer them.

I _____, have read and understand the above policy regarding missed appointments.

Print Name

_____ _____

Signature **Date**

TOTAL FAMILY WELLNESS

1831 N. Belcher RD ▪ Suite C3 ▪ Clearwater, FL 33765 ▪ Phone: 727-754-4959 ▪ Fax: 727-754-5910

Authorization to Release Protected Information

Patient Name:	Date of Birth:

Instructions: Following section to be completed by office. Last section is to be completed by Patient or Guardian.

Release Information From	**Release Information To**
☐ Total Family Wellness 1831 N. Belcher RD Suite C3 Clearwater, FL 33765	☐ Total Family Wellness 1831 N. Belcher RD Suite C3 Clearwater, FL 33765
☐ Other *(Specify facility/individual & address below, including phone/fax if known).*	☐ Other *(Specify facility/individual & address below, including phone/fax if known).*
_____	_____
_____	_____
_____	_____
_____	_____

Purpose of Release

☐ Treatment/Continued care	☐ Personal	☐ Legal purposes
☐ Application for insurance	☐ Disability determination	☐ Payment of insurance claim
☐ Other		

Information To Be Released

(Required - check all that apply)

☐ Clinic notes	☐ Hospital discharge summary	☐ Laboratory reports	☐ Radiology reports
☐ History and physical	☐ EKG's	☐ Operative reports	☐ Radiology images
☐ Hospital notes	☐ Immunization records	☐ Pathology reports	☐ Billing information

☐ Other (specify information to be released in the space below)

Service dates (optional) From To	Information needed by (optional)

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  ☐ Parent ☐ Legal Guardian

Signature *(Required)*	**Date Signed** *(Required)* *(Month DD, YYYY)*
Printed Name of Person Signing *(If Not Patient)*	
Mailing Address of Patient - Street	

City	State	ZIP Code	Phone

Date _____

Total Family Wellness

New Patient History

(Please Print Clearly)

Patient Name: _____ **Date of Birth**:_____/____/_____

Sex: Male____ Female ____

Reason for Visit: (Please list your major medical concerns)

_____

_____

Allergies	Reaction

MEDICATIONS Please list all medications you are taking including prescription, over the counter, vitamins and herbal

(Please list each Medication and dosage)

Medication Name	Dosage	How Many Times a Day?	Refill Needed? Yes / No

Preferred Pharmacy _____ _____

Name **Location/Address**

Patient Initials_____

Date_____

Name_____ DOB _____

PAST MEDICAL HISTORY

Medical History – Please check any of the following that you have been diagnosed with.

- □ Anorexia/Bulimia
- □ Anemia
- □ Anxiety/Depression
- □ Arthritis
- □ Asthma
- □ Bleeding Disorder
- □ Blocked Arteries
- □ Blood Clots
- □ Bronchitis
- □ Cancer Type:_____
- □ Cataracts
- □ Chronic Constipation
- □ Colon Polyps
- □ COPD
- □ Macular Degeneration
- □ Degenerative Disc Disease
- □ Diabetes/Pre-Diabetes
- □ Diverticulitis
- □ Emphysema
- □ Frequent Urinary Infections
- □ Gallstones
- □ GERD
- □ Glaucoma
- □ Gout
- □ Headaches
- □ Heart Attack
- □ Heart Failure
- □ Heart Murmur
- □ Hemorrhoids
- □ Hepatitis
- □ Herniated Disc
- □ High Blood Pressure
- □ High Cholesterol/Triglycerides
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Inflammatory Bowel Disease
- □ Insomnia
- □ History of Blood Transfusion
- □ Irritable Bowel Syndrome
- □ Kidney Disease
- □ Kidney Stones
- □ Meningitis
- □ Obesity
- □ Osteopenia
- □ Osteoporosis
- □ Peripheral Vascular Disease/Poor Circulation
- □ Pneumonia
- □ Prostate Problems
- □ Rheumatic Fever
- □ Seasonal Allergies
- □ Seizures
- □ Sleep Apnea
- □ Stroke
- □ Tuberculosis
- □ Varicose Veins
- □ Ulcers
- □ Alcohol Abuse Quit Date: _____
- □ Substance Abuse Quit Date:_____

Any Others:_____

Surgical / Procedure History – Please check any of the following you have had, and list the month/year performed.

- □ Appendectomy _____
- □ Bunionectomy _____
- □ Carotid Surgery _____
- □ D&C _____
- □ Lumpectomy _____
- □ Lasik Surgery _____
- □ Tonsillectomy _____
- □ Tubal Ligation _____
- □ Uterus Removal _____
- □ C-Section _____
- □ Cataract Removal _____
- □ Hemorrhoidectomy _____
- □ Hip Surgery _____
- □ Kidney Stones _____
- □ Hip Replacement _____
- □ Prostate Removed _____
- □ Ovaries Removed _____
- □ Joint Surgery _____
- □ Cardiac Bypass _____
- □ Gallbladder Removal _____
- □ Hernia Repair _____
- □ Cardiac Stents _____
- □ Thyroidectomy _____
- □ Knee Replacement _____
- □ Vasectomy _____
- □ Back Surgery _____

Any Others:_____

Hospitalizations – Please list any other hospitalizations you may have had.

1. Reason: _____
   Date: _____
   Hospital: _____
2. Reason: _____
   Date: _____
   Hospital: _____
3. Reason: _____
   Date: _____
   Hospital: _____
4. Reason: _____
   Date: _____
   Hospital: _____

Women's Health

Number of Vaginal Deliveries:_____
Number of Miscarriages:_____
Number of Abortions:_____
Age of First Period:_____

Number of Pregnancies:_____
Number of C-Sections:_____
Abnormal PAP's?_____

Patient Initials_____

Date_____

Name_____ DOB _____

PHYSICIANS YOU HAVE RECENTLY SEEN

Prior Primary Care Physician: Name: _____ Location: _____

Specialists: Please list most recent physician and specialists you see or have seen;

Name:_____
Type of Doctor: _____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor:_____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor: _____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor:_____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

HEALTH MAINTENANCE

If you have had any of the following performed, please check the box and list the month/year

□ Last Physical Exam _____
□ Last EKG _____
□ Last Eye Exam _____
□ Labs including a Cholesterol Screen _____

□ Mammogram (Females Only) _____
□ Clinical Breast Exam (Females Only) _____
□ Pap Smear (Females Only) _____
□ Bone Density _____

□ Colonoscopy _____
□ Fecal Occult Blood Test (Blood in stool) _____

□ PSA (Males Only) _____

□ Shingles Vaccine (Zostavax) _____
□ Human Papilloma Virus Vaccine (HPV-Gardasil) _____
□ Vaccines Against Hepatitis _____
□ Influenza Vaccine _____

□ Tetanus Diphtheria (Td) _____
□ Tetanus Diphtheria Pertusis (Tdap) _____
□ Pneumonia Vaccine (Pneumovax) _____
□ TB Screening _____

SOCIAL HISTORY

What is your current marital status? □ **Single** □ **Married** □ **Divorced** □ **Widowed** □ **Other:** _____

Number of Children: _____ Ages of Children: _____

With whom do you currently live?
□ **Self** □ **Sibling** □ **Spouse** □ **Spouse/Children** □ **Parents** □ **Significant Other** □ **Friend/Roommate**

Your Occupation: _____ If retired, from what: _____

Please indicate the highest level of education you have received:

_____

Hobbies/interests and physical activities: _____

Please list any dietary restrictions or special diets you may follow: _____

Regular Exercise **YES** **NO** Type:_____Frequency:_____

Patient Initials_____

Date_____

Name_____ DOB _____

Operate a motor vehicle? **YES** **NO** Use a seatbelt? **YES** **NO**

Hazardous chemicals labeled & kept in a safe place? **YES** **NO**

Do you know the number to Poison Control Center? **YES** **NO**

Do you currently use tobacco products? **NO** **YES** Type: _____

Amount per day? _____How long have you used? _____

Do you have a history of using tobacco products? **NO** **YES** Type & Amount: _____

How long did you use: _____When did you quit? _____

How much alcohol do you typically drink in **one week?**

□ **I do not drink alcohol** □ **Less than one** □ **Drinks per week:**_____

Do you use drugs? **NO** **YES** What type? _____ Do you have a history of drug addiction? **YES** **NO**

Are you sexually active? **YES** **NO** **NEVER** Do you use condoms? **YES** **NO**

Sexual Partners: **Male**_____ **Female**_____ **Both**_____

Do you have any history of STD's? **NO** **YES** If **YES**, what type? _____

The CDC recommends that everyone be screened for HIV. Do you have any concerns about possible exposure that you would like to discuss or be tested for? **YES** **NO**

Are you currently, or have you ever been, a victim of domestic violence? **YES** **NO**

Do you have any spiritual/religious needs/restrictions? If so, please indicate:_____

_____

_____

Do you need help with the following? (check everything that applies)

_____Dressing
_____Toileting
_____Bathing or showering
_____Walking
_____Eating
_____Getting in and out of bed
_____Checkbook balancing
_____Shopping
_____Answering the phone
_____Taking your medications

Patient Initials_____

Date_____

Name_____ DOB _____

During the **past four weeks**, have you often been bothered by feeling down, depressed or hopeless? **YES NO**

During the **past four weeks**, have you often been bothered by lack of interest or pleasure in doing things? **YES NO**

During the **past four weeks**, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself)

YES, as much as I wanted YES, quite a bit YES, some YES, a little NO, not at all

Have you fallen in the past year? **YES NO**

Do you have complaints of balance or difficulty walking? **YES NO**

How often do you have trouble taking medications the way you have been told to take them?

- ❒ **I do not have to take medicine**
- ❒ **I always take them as prescribed**
- ❒ **Sometimes I take them as prescribed**
- ❒ **I seldom take them as prescribed**

If you do have trouble, are there specific barriers that interfere with medication adherence?

Please check all that apply:

- ❒ **Cost/Financial constraints**
- ❒ **Remembering doses**
- ❒ **Understanding importance of taking medications**
- ❒ **Ability to read prescription labels or instructions**
- ❒ **Religious beliefs**
- ❒ **Cultural differences**
- ❒ **Other:**

Do you have an advanced directive/living will? **YES NO**

Would you like to discuss living wills/advanced directives with your provider today? **YES NO**

If you use any other medical suppliers (oxygen, CPAP, home health, etc.) please list those company names below:

_____

_____

_____

_____

_____

Patient Initials_____

Date_____

Name_____ DOB _____

Self-Care and Self-Management Questions

As partners in your health care, we recognize the importance of understanding how comfortable you feel in managing your health. Below are questions that will help us better serve your needs:

How confident are you that you can control and manage most of your health problems?
VERY CONFIDENT SOMEWHAT CONFIDENT NOT VERY CONFIDENT I DO NOT HAVE HEALTH PROBLEMS

How confident are you that you can judge when the changes in your health mean you should visit a doctor?
VERY CONFIDENT SOMEWHAT CONFIDENT NOT VERY CONFIDENT

How confident are you that you can do the different tasks and activities needed to manage your health so as to reduce your need to see a doctor?
VERY CONFIDENT SOMEWHAT CONFIDENT NOT VERY CONFIDENT

How confident are you that you can control any emotional distress or health problems you have so that they don't interfere with your everyday life and the things you want to do?
VERY CONFIDENT SOMEWHAT CONFIDENT NOT VERY CONFIDENT

How confident are you that you can do things other than just take medication to reduce how much a health condition affects your everyday life?
VERY CONFIDENT SOMEWHAT CONFIDENT NOT VERY CONFIDENT

How confident are you that you can get emotional support from resources other than friends and family, if needed?
VERY CONFIDENT SOMEWHAT CONFIDENT NOT VERY CONFIDENT

How confident are you that you can get help with your daily tasks (such as housecleaning, yard work, meals or personal hygiene) from resources other than friends and family, if needed?
VERY CONFIDENT SOMEWHAT CONFIDENT NOT VERY CONFIDENT

Would you be willing to obtain support from local resources (smoking cessation, weight management programs, hospice, etc.) to help manage your health if referred by your provider? **YES NO**

Patient Initials_____

Name_____ DOB _____ Date_____

	Deceased? Y/N	Current age or age at death	Aneurysm	Arthritis	High BP	Heart Problems	High Cholesterol	Lung Problems	Gout	Stroke	Seizures/Epilepsy	Breast Cancer	Skin Cancer	Ovarian Cancer	Colon Cancer	Prostate Cancer	Diabetes	Kidney Disease	Thyroid Problems	Osteoporosis	Bleeding Problem	Allergies/Asthma	Mental Illness	Tuberculosis	Others (list)
Father																									
Mother																									
Paternal Grandfather																									
Paternal Grandmother																									
Maternal Grandfather																									
Maternal Grandmother																									
Brother																									
Brother																									
Sister																									
Sister																									
Son/Daughter																									
Son/Daughter																									
Other																									
Other																									

Check the appropriate item listed across the top row for each relative. Please list only blood relatives.

Patient Initials_____

Date_____

Name_____ DOB _____

Please check any of the following symptoms that you are currently experiencing or have experienced in the last 7-10 days.

GENERAL
- □ Recent Fever
- □ Excessive Fatigue
- □ Unexplained Weight Loss/Gain

EYES
- □ Discharge
- □ Pain or Burning
- □ Blurred Vision
- □ Loss of Sight
- □ Itching or Watering

BREAST
- □ Pain
- □ Lumps
- □ Nipple Discharge

RESPIRATORY
- □ Cough
- □ Coughing up Blood
- □ Shortness of Breath
- □ Wheezing
- □ Snoring

REPRODUCTIVE-WOMEN
- □ Irregular Periods
- □ Spotting between periods
- □ Vaginal discharge/burning/itching
- □ Unusually painful periods
- □ Pain/Trouble during intercourse

REPRODUCTIVE-MEN
- □ Discharge from Penis
- □ Pain or Swelling of Testicles
- □ Pain/Trouble during intercourse
- □ Problems with Erection

MENTAL HEALTH
- □ Thoughts of Suicide
- □ Marital Problems
- □ Trouble Sleeping
- □ Panic Attacks
- □ Anxiety
- □ Thoughts of Harming Others

SKIN
- □ Change in Nails
- □ Lumps
- □ Recurrent Rashes
- □ Sores that will not heal or bleed
- □ Moles that are changing

EARS
- □ Hearing Loss
- □ Ringing
- □ Earache
- □ Feeling of Ear Fullness

MOUTH & THROAT
- □ Dry Mouth
- □ Soreness or Bleeding in mouth area
- □ Sore Throat
- □ Mouth Ulcers
- □ Hoarseness
- □ Dental Issues

ENDOCRINE
- □ Unusual intolerance of heat
- □ Unusual intolerance of cold
- □ Excessive Thirst
- □ Excessive Hunger

URINARY
- □ Pain/Burning with Urination
- □ Frequent Urination
- □ Blood in Urine
- □ Trouble starting to Urinate
- □ Waking up to Urinate
- □ Leakage of Urine
- □ Change in Stream

NERVOUS SYSTEM
- □ Headaches
- □ Seizures/Convulsions
- □ Fainting Spells
- □ Frequent Memory Loss
- □ Weakness
- □ Shakiness or Tremor
- □ Loss of Sensation/Numbness
- □ Feeling of Tingling in Limb
- □ Speech Difficulty

NOSE & SINUSES
- □ Bleeding
- □ Nasal Congestion
- □ Sneezing
- □ Loss of Sense of Smell

NECK
- □ Pain
- □ Lumps

CARDIOVASCULAR
- □ Abnormal/Irregular Heart Beat
- □ Chest Pain
- □ Awaken at night with breathing problems
- □ Passing Out
- □ Shortness of Breath
- □ Swelling of Ankles
- □ Leg Pain/Resting
- □ Leg Pain/Walking

GASTROINTESTINAL
- □ Unable to eat certain foods
- □ Loss of Appetite/Weight
- □ Food sticks in throat
- □ Painful Swallowing
- □ Heartburn
- □ Indigestion
- □ Vomiting
- □ Nausea
- □ Vomiting Blood
- □ Abdominal or Stomach Pain
- □ Diarrhea
- □ Constipation
- □ Recent Change in Bowel Habits
- □ Blood in Stools
- □ Black Stools

MUSCULOSKELETAL
- □ Joint Pain
- □ Joint Stiffness
- □ Muscle Soreness

BLOOD DISORDERS
- □ Easy Bruising
- □ Excessive Bleeding

Patient Initials_____