

**Confidential Health History Information**

**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Patient Information**  Name(first)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ Sex (Circle One) M / F / M to F / F to M  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home/Cell/work (circle one)  Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  # of hours worked per week:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Primary Emergency Contact**  Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please list all authorized persons you give permission to inquire about and make changes to scheduling, rescheduling, and canceling appointments.**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_

**Current Health Care**

Are you currently receiving health care? Y/N

If yes, Where and from Whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, where did you last receive health care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have reviewed the Notice of Privacy Practices of Sunnyside Collaborative Care

(Please initial one of the following options and sign below.)

\_\_\_\_\_\_\_\_\_\_ I wish to receive a paper copy of Privacy Notice.

\_\_\_\_\_\_\_\_\_\_ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can

request a copy at any time and the Privacy Notice is posted in the office.

**PATIENT CONSENT TO TREATMENT**

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

A patient coming to Sunnyside Collaborative Care to see a provider gives his/her permission and authority for care by them in accordance with appropriate test, diagnosis, and analysis. The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I hereby consent to the provision of diagnosis, care, and/or treatment by **Sunnyside Collaborative Care Providers**.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to theprovision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers.

**I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Sunnyside Collaborative Care providers reserve the right to terminate the doctor-patient relationship if patient is continually unable to comply with reasonable treatment plans, schedules, or behaves in a manner deemed inappropriate by the doctor or staff*.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient or Person Date

**FINANCIAL RESPONSIBILITY**

**PLEASE READ THIS DOCUMENT CAREFULLY. BY EXECUTING THIS CONTRACT, YOU AGREE TO ALL RIGHTS, DUTIES, AND RESPONSIBILITIES STATED HEREIN.**

1. **If you do not have insurance, or do not provide insurance at time of service.** All payments are to be paid in full at the time of service.

2. **If You Have Insurance.** All owed deductibles and co-payments are to be paid within 90 days of service provided.

3. **Self Pay Patient.** All payments are to be paid at the time of services. You are a self pay patient until you submit insurance cards, and SCC qualifies and accepts your insurance coverage.

4. **Reasonable Fees.** SCC fees are usual, customary, and reasonable according to professional industry standard, and, therefore, are covered up to the maximum allowance determined by each carrier.

5**. Patient Financial Responsibilities:**

* I understand is it my responsibility to contact my insurance company should I have a dispute with coverage.
* I hereby authorize the release of all information necessary to secure payment for services rendered.
* I understand I am financially responsible for all charges, whether or not they are covered by insurance.
* I understand if I disagree with any charges, I will contact the office in writing within 30 days of billing date.
* Should legal action be taken by this office to collect an unpaid balance due for services provided, I agree to pay reasonable attorney’s fees or other such costs as the court determines proper.
* I understand it is my responsibility to provide accurate and up to date insurance information at or before my scheduled appointment.

*I have read, understood and agree to the policies described above*.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Responsible Party or Guardian Date:

**Cancellation Policy/No Show Policy for Doctor Appointments**

1. **Cancellation/No Show Policy for Doctor Appointment**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “Full” appointment book.

**If any appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Patient/Guardian Date**

**Chiropractic Consent Form**

Chiropractic examination and therapeutic procedures (including spinal adjustment, cold laser, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help have complications. While the chances of experiencing complications are small, it is the practice of his clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, temporary worsening of symptoms. More serious complications are rare and their association with spinal adjustments (manipulation) is debated. Serious complications are estimated to be in the range of .5-2 incidents per million adjustments of the neck and 1 per million for adjustments of the low back. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurological impairment, injuries to spinal discs, and spinal fractures. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

Please read the following carefully:

I understand that I have any prosthetics or surgical implants (Including breast implants, and artificial joint, etc.) I should discuss this with my practitioner as it may affect care.

**Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT SIGNATURE (*Or Patient Representative*)**

**ACUPUNCTURE INFORMED CONSENT TO TREAT**

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by an acupuncturist at Sunnyside Collaborative Care.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). The clinic uses sterile disposable needles and maintains a clean and safe environment, but infection is another possible risk. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I reserve the right to bring a companion with me to any of my appointments if I choose so.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT SIGNATURE (*Or Patient Representative*)**

**Insurance Information**

**Auto/Worker’s Comp Insurance**

Is condition due to accident? Auto / Work

Accident Date:\_\_\_/\_\_\_/\_\_\_ Claim Filed? Y N

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance company Billing address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adjuster Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group Health Insurance (Primary Insurance)**

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Plan #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Group Health Insurance (Secondary Insurance)**

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Plan #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL MEDICAL HISTORY**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What are your most important health concerns?

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

List any surgeries, hospitalizations, imaging (CT, MRI, EEG, EKG, etc), please include dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**IMMUNIZATION HISTORY**

□Polio □ Tetanus shot □Measles/Mumps/Rubella □ HPV □Hepatitis A □Pertussis □Diphtheria

□ Chicken pox □Tuberculosis □Hepatitis B □ HIB □Flu shot Date? \_\_\_\_\_\_\_\_\_\_\_ □Others\_\_\_\_\_\_\_\_\_\_\_\_

Childhood Illness: □Chicken Pox □Mononucleosis □ Rubella □German Measles □ Diptheria □Strep Throat □Tuberculosis □ Scarlet Fever

**Women**:

Pap smear Date:\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Normal [ ] Abnormal Mammogram Date:\_\_\_\_\_\_\_\_\_\_\_\_ [ ] Normal [ ] Abnormal

**Men**:

[ ] PSA (prostate) Date:\_\_\_\_\_\_\_\_\_\_\_\_ PSA number? \_\_\_\_\_\_\_\_\_

**Tobacco Use**

Smoke Cigarettes: [ ] Yes, currently [ ] Yes, in the past. Date quit:\_\_\_\_\_\_\_ [ ] Never smoked

If you marked Yes, currently or past, please indicate: Packs per day:\_\_\_\_\_\_ Years of use:\_\_\_\_\_\_

Other tobacco use: [ ] Pipe/Cigar/Chew/Snuff Years of Use:\_\_\_\_\_\_\_\_\_

**Alcohol use**

Do you drink alcohol? [ ] Never [ ] Past # drinks/wk:\_\_\_\_\_\_\_ [ ] Currently # drinks/wk:\_\_\_\_\_\_\_

Have you been treated for alcoholism? [ ] Yes [ ] No

**Drug use**

Do you use recreational drugs? [ ] Yes [ ] No [ ] Yes, in the past only

If **yes**, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caffeine Intake**

Do you drink caffeinated versions of the following (please **circle**): coffee tea soda cocoa

How much of the previously circled beverages do you drink in one day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much plain water do you drink in one day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

***Answer or check those applicable:***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Father** | **Mother** | **Brothers** | **Sisters** | **Spouse** | **Children** |
| Age (if living) |  |  |  |  |  |  |
| Health G= good P= poor |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |
| Asthma, Hay fever, Hives |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |
| Age (at death) |  |  |  |  |  |  |
| Cause of death |  |  |  |  |  |  |

**MEDICATION LIST and SUPPLEMENT LIST**

List all medications you are currently taking.

|  |  |  |  |
| --- | --- | --- | --- |
| Date Started | Name of Medication & Strength (ex. Mg, units) | How to take (ex: take 1 tablet by mouth 2 times daily) | Why are you taking this medicine |
|  |  |  |  |
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**List all Allergies (Medication, Food, Animals, ect.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REVIEW OF SYSTEMS**

**For the following please circle: Y = Yes/Current issue N = No/Never had P = Past problem**

**MENTAL/EMOTIONAL**

Depression Y N P

Mood Swings Y N P

Anxiety/Nervousness Y N P

Tension Y N P Memory Problems Y N P

Poor Concentration Y N P

Considered suicide Y N P

Attempted suicide Y N P

**SKIN**

Rashes Y N P

Itching Y N P

Changes in skin color Y N P

Acne/boils Y N P

Eczema Y N P

Lumps/bumps Y N P

Hair Loss Y N P

**HEAD**

Headaches Y N P

Head Injury Y N P

Jaw issues or TMJ Y N P

**NECK**

Lumps in neck Y N P

Swollen Glands Y N P

Goiter Y N P

Pain or Stiffness in neck Y N P

**EYES**

Impaired Vision Y N P

Glasses or Contacts Y N P

Eye Pain or strain Y N P

Tearing or dryness Y N P

Double Vision Y N P

Glaucoma Y N P

Cataracts Y N P

Color blindness Y N P

**EARS**

Impaired hearing Y N P

Ringing in ears Y N P

Earaches Y N P

History of ear infections Y N P

**NOSE, THROAT, MOUTH**

Stuffy nose Y N P

Frequent Colds Y N P

Frequent sore throats Y N P

Sinusitis Y N P

Hoarseness Y N P

Sore Tongue or lips Y N P

Gum Problems Y N P

Tooth Problems Y N P

Teeth grinding Y N P

**RESPIRATORY**

Cough Y N P

Excess Sputum Y N P

Coughing up Blood Y N P

Wheezing Y N P

Asthma Y N P

Bronchitis Y N P

Pneumonia Y N P

Pleurisy Y N P

Emphysema Y N P

Pain with Breathing Y N P

Shortness of Breath Y N P

-Lying down? Y N P

Tuberculosis Y N P

**CARDIOVASCULAR**

High Blood Pressure Y N P

Heart Disease Y N P

Angina Y N P

Chest Pain Y N P

Murmurs Y N P

Rheumatic Fever Y N P

Swelling in ankles Y N P

Palpitations, Fluttering Y N P

**PERIPHERAL VASCULAR**

Deep Leg Pain Y N P

Cold Hands and Feet Y N P

Varicose Veins Y N P

Thrombophlebitis Y N P

**BLOOD**

Anemia Y N P

Easy Bleeding or Bruising Y N P

Previous Blood Transfusion Y N P

**GASTROINTESTINAL**

Trouble Swallowing? Y N P

Change in Thirst Y N P

Change in Appetite Y N P

Nausea Y N P

Vomiting Y N P

Vomiting Blood Y N P

Bowel Movements: Frequency? \_\_\_\_\_

Is this a change? Y N P

Blood in Stool Y N P

Black stools Y N P

Diarrhea Y N P

Constipation Y N P

Abdominal pain or cramps Y N P

Heartburn Y N P

Belching or passing gas Y N P

Jaundice (yellow skin) Y N P

Liver Disease Y N P

Gall Bladder Disease Y N P

Ulcer Y N P

Hemorrhoids Y N P

**URINARY**

Pain on Urination Y N P

Increased Frequency Y N P

Frequency at Night Y N P

Inability to hold urine Y N P

Frequent infections Y N P

Kidney Stones Y N P

**NEUROLOGIC**

Fainting Y N P

Vertigo or Dizziness Y N P

Seizures Y N P

Paralysis Y N P

Muscle Weakness Y N P

Numbness/Tingling Y N P

Loss of Memory Y N P

Loss of Balance Y N P

**ENDOCRINE**

Hypothyroid Y N P

Heat/Cold Intolerance Y N P

Excessive Thirst Y N P

Excessive Hunger Y N P

Fatigue Y N P

Hyperthyroid Y N P

Diabetes Y N P

-Type 1 or 2? \_\_\_\_\_\_\_

Seasonal depression Y N P

**MUSCULOSKELETAL**

Joint Pain or Stiffness Y N P

Arthritis Y N P

Broken Bones Y N P

Muscle Spasms Y N P

Weakness Y N P

Sciatica Y N P

**IMMUNE**

Reactions to vaccines Y N P

Persistent swollen glands Y N P

Slow wound healing Y N P

Chronic fatigue Y N P

Chronic infections Y N P

Night sweats Y N P

**BREASTS**

Do you perform self-exams? Y N P

Breast Lumps Y N P

Pain or Tenderness? Y N P

Nipple discharge? Y N P

**FEMALE REPRODUCTIVE**

Are you sexually active? Y N P

Sexual orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth control? Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age of first Menses \_\_\_\_\_\_\_\_\_\_\_

Age of Last Menses if

menopausal:\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Pap smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal Pap smear? Y N P

If yes, date:\_\_\_\_\_\_\_\_\_

Duration of Menses: \_\_\_\_\_\_\_\_\_ days

Length of Cycle: \_\_\_\_\_\_\_\_\_ days

Regular Cycles Y N P

Bleeding Between Periods Y N P

Painful Menses Y N P

Excessive/Heavy Flow Y N P

PMS? Y N P

If so, what symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menopausal Symptoms Y N P

Vaginal odor Y N P

Vaginal Discharge Y N P

Endometriosis Y N P

Ovarian Cysts Y N P

Gonorrhea Y N P

Chlamydia Y N P

Genital Warts Y N P

Herpes Y N P

Syphilis Y N P

Pain with Intercourse Y N P

Sexual Difficulties Y N P

Difficulty Conceiving Y N P

Number of Pregnancies: \_\_\_\_\_\_\_\_\_\_

Number of Live Births: \_\_\_\_\_\_\_\_\_\_\_

Number of Miscarriages:\_\_\_\_\_\_\_\_\_\_

Number of Abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_

**MALE REPRODUCTIVE**

Are you sexually active? Y N

Sexual orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth control? Type: \_\_\_\_\_\_\_\_\_\_\_\_\_

Hernias Y N P

Testicular Masses Y N P

Testicular Pain Y N P

Penile Discharge or Sores Y N P

Gonorrhea Y N P

Chlamydia Y N P

Genital Warts Y N P

Herpes Y N P

Syphilis Y N P

Prostate Disease Y N P

-What Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Impotence Y N P

Premature Ejaculation Y N P